

Growth - 100's
416.926 Act
FE
24 hour care

See especially
the pages
with tabs

the "listings"
Σ

administrative law judge's recommended decision. In these court-recommended cases reaching the administrative law judge, we will follow the same rules provided in paragraphs (1) (1), (2), (3), (4) and (5) of this section.

(j) *Responsibility to pay back continued benefits.* (1) If the final decision of the Secretary affirms the determination that you are not entitled to benefits, you will be asked to pay back any continued benefits you receive. However, as described in the overpayment recovery and waiver provisions of subpart F of this part, you will have the right to ask that you not be required to pay back the benefits. You will not be asked to pay back any Medicare benefits you received during the appeal.

(2) Anyone else receiving benefits based on your wages and self-employment income (or because of your disability) will be asked to pay back any continued benefits he or she received if the determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling, is not changed by the final decision of the Secretary. However, he or she will have the right to ask that he or she not be required to pay them back, as described in the overpayment recovery and waiver provisions of subpart F of this part. He or she will not be asked to pay back any Medicare benefits he or she received during the appeal.

(3) Waiver of recovery of an overpayment resulting from the continued benefits paid to you or anyone else receiving benefits based on your wages and self-employment income (or because of your disability) may be considered as long as the determination was appealed in good faith. It will be assumed that such appeal is made in good faith and, therefore, any overpaid individual has the right to waiver consideration unless such individual fails to cooperate in connection with the appeal, e.g., if the individual fails (without good reason) to give us medical or other evidence we request, or to go for a physical or mental examination when requested by us, in connection with the appeal. In determining whether an individual has good cause for failure to cooperate and, thus, whether an appeal was made in good faith, we will take into account

any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual may have which may have caused the individual's failure to cooperate.

[53 FR 29020, Aug. 2, 1988; 53 FR 39015, Oct. 4, 1988, as amended at 57 FR 1383, Jan. 14, 1992; 59 FR 1635, Jan. 12, 1994]

§ 404.1598 If you become disabled by another impairment(s).

If a new severe impairment(s) begins in or before the month in which your last impairment(s) ends, we will find that your disability is continuing. The new impairment(s) need not be expected to last 12 months or to result in death, but it must be severe enough to keep you from doing substantial gainful activity, or severe enough so that you are still disabled under § 404.1594.

[50 FR 50136, Dec. 6, 1985]

§ 404.1599 Work incentive experiments and rehabilitation demonstration projects in the disability program.

(a) *Authority and purpose.* Section 505(a) of the Social Security Disability Amendments of 1980, Pub. L. 96-265, directs the Secretary to develop and conduct experiments and demonstration projects designed to provide more cost-effective ways of encouraging disabled beneficiaries to return to work and leave benefit rolls. These experiments and demonstration projects will test the advantages and disadvantages of altering certain limitations and conditions that apply to title II disabled beneficiaries. The objective of all work incentive experiments or rehabilitation demonstrations is to determine whether the alternative requirements will save Trust Fund monies or otherwise improve the administration of the disability program established under title II of the Act.

(b) *Altering benefit requirements, limitations or conditions.* Notwithstanding any other provision of this part, the Secretary may waive compliance with the entitlement and payment requirements for disabled beneficiaries to carry our experiments and demonstration projects in the title II disability program. The projects involve altering certain limitations and conditions that

currently apply to applicants and beneficiaries to test their effect on the program.

(c) *Applicability and scope—(1) Participants and nonparticipants.* If you are selected to participate in an experiment or demonstration project, we may temporarily set aside one or more of the current benefit entitlement or payment requirements, limitations or conditions and apply alternative provisions to you. We may also modify current methods of administering the Act as part of a project and apply alternative procedures or policies to you. The alternative provisions or methods of administration used in the projects will not disadvantage you in contrast to current provisions, procedures or policies. If you are not selected to participate in the experiments or demonstration projects (or if you are placed in a control group which is not subject to alternative requirements and methods) we will continue to apply to you the current benefit entitlement and payment requirements, limitations and conditions and methods of administration in the title II disability program.

(2) *Alternative provisions or methods of administration.* The alternative provisions or methods of administration that apply to you in an experiment or demonstration project may include (but are not limited to) one or more of the following:

(i) Reducing your benefits (instead of not paying) on the basis of the amount of your earnings in excess of the SGA amount;

(ii) Extending your benefit eligibility period that follows 9 months of trial work, perhaps coupled with benefit reductions related to your earnings;

(iii) Extending your Medicare benefits if you are severely impaired and return to work even though you may not be entitled to monthly cash benefits;

(iv) Altering the 24-month waiting period for Medicare entitlement; and

(v) Stimulating new forms of rehabilitation.

(d) *Selection of participants.* We will select a probability sample of participants for the work incentive experiments and demonstration projects from newly awarded beneficiaries who meet certain pre-selection criteria (for ex-

ample, individuals who are likely to be able to do substantial work despite continuing severe impairments). These criteria are designed to provide larger subsamples of beneficiaries who are not likely either to recover medically or die. Participants may also be selected from persons who have been receiving DI benefits for 6 months or more at the time of selection.

(e) *Duration of experiments and demonstration projects.* A notice describing each experiment or demonstration project will be published in the FEDERAL REGISTER before each experiment or project is placed in operation. The work incentive experiments and rehabilitation demonstrations will be activated in 1982. A final report on the results of the experiments and projects is to be completed and transmitted to Congress by June 9, 1993. However, the authority for the experiments and demonstration projects will not terminate at that time. Some of the alternative provisions or methods of administration may continue to apply to participants in an experiment or demonstration project beyond that date in order to assure the validity of the research. Each experiment and demonstration project will have a termination date (up to 10 years from the start of the experiment or demonstration project).

[48 FR 7575, Feb. 23, 1983, as amended at 52 FR 37605, Oct. 8, 1987; 55 FR 51687, Dec. 17, 1990]

APPENDIX 1 TO SUBPART P—LISTING OF IMPAIRMENTS

The body system listings in parts A and B of the Listing of Impairments will no longer be effective on the following dates unless extended by the Commissioner or revised and promulgated again.

1. Growth Impairment (100.00): December 6, 1996.
2. Musculoskeletal System (1.00 and 101.00): June 6, 1996.
3. Special Senses and Speech (2.00 and 102.00): December 4, 1998.
4. Respiratory System (3.00 and 103.00): October 7, 2000.
5. Cardiovascular System (4.00 and 104.00): February 10, 1998.
6. Digestive System (5.00 and 105.00): December 5, 1997.
7. Genito-Urinary System (6.00 and 106.00): December 5, 1997.
8. Hemile and Lymphatic System (7.00 and 107.00): June 6, 1997.

9. Skin (8.00): June 6, 1997.
10. Endocrine System and Obesity (9.00) and Endocrine System (109.00): June 6, 1997.
11. Multiple Body Systems (110.00): July 2, 1998.
12. Neurological (11.00 and 111.00): June 5, 1998.
13. Mental Disorders (12.00): August 28, 1997.
14. Mental Disorders (112.00): June 12, 1997.
15. Neoplastic Diseases, Malignant (13.00 and 113.00): June 6, 1997.
16. Immune System (14.00 and 114.00): July 2, 1998.

Part A

Criteria applicable to individuals age 18 and over and to children under age 18 where criteria are appropriate.

- Sec.
- 1.00 Musculoskeletal System.
- 2.00 Special Senses and Speech.
- 3.00 Respiratory System.
- 4.00 Cardiovascular System.
- 5.00 Digestive System.
- 6.00 Genito-Urinary System.
- 7.00 Hemic and Lymphatic System.
- 8.00 Skin.
- 9.00 Endocrine System and Obesity.
- 10.00 [Reserved]
- 11.00 Neurological.
- 12.00 Mental Disorders.
- 13.00 Neoplastic Diseases, Malignant.
- 14.00 Immune System.

1.00 MUSCULOSKELETAL SYSTEM

A. *Loss of function* may be due to amputation or deformity. Pain may be an important factor in causing functional loss, but it must be associated with relevant abnormal signs or laboratory findings. Evaluations of musculoskeletal impairments should be supported where applicable by detailed descriptions of the joints, including ranges of motion, condition of the musculature, sensory or reflex changes, circulatory deficits, and X-ray abnormalities.

B. *Disorders of the spine*, associated with vertebrogenic disorders as in 1.05C, result in impairment because of distortion of the bony and ligamentous architecture of the spine or impingement of a herniated nucleus pulposus or bulging annulus on a nerve root. Impairment caused by such abnormalities usually improves with time or responds to treatment. Appropriate abnormal physical findings must be shown to persist on repeated examinations despite therapy for a reasonable presumption to be made that severe impairment will last for a continuous period of 12 months. This may occur in cases with unsuccessful prior surgical treatment.

Evaluation of the impairment caused by disorders of the spine requires that a clinical diagnosis of the entity to be evaluated first must be established on the basis of adequate history, physical examination, and roent-

genograms. The specific findings stated in 1.05C represent the level required for that impairment; these findings, by themselves, are not intended to represent the basis for establishing the clinical diagnosis. Furthermore, while neurological examination findings are required, they are not to be interpreted as a basis for evaluating the magnitude of any neurological impairment. Neurological impairments are to be evaluated under 11.00-11.19.

The history must include a detailed description of the character, location, and radiation of pain; mechanical factors which incite and relieve pain; prescribed treatment, including type, dose, and frequency of analgesic; and typical daily activities. Care must be taken to ascertain that the reported examination findings are consistent with the individual's daily activities.

There must be a detailed description of the orthopedic and neurologic examination findings. The findings should include a description of gait, limitation of movement of the spine given quantitatively in degrees from the vertical position, motor and sensory abnormalities, muscle spasm, and deep tendon reflexes. Observations of the individual during the examination should be reported; e.g., how he or she gets on and off the examining table. Inability to walk on heels or toes, to squat, or to arise from a squatting position, where appropriate, may be considered evidence of significant motor loss. However, a report of atrophy is not acceptable as evidence of significant motor loss without circumferential measurements of both thighs and lower legs (or upper or lower arms) at a stated point above and below the knee or elbow given in inches or centimeters. A specific description of atrophy of hand muscles is acceptable without measurements of atrophy but should include measurements of grip strength.

These physical examination findings must be determined on the basis of objective observations during the examination and not simply a report of the individual's allegation, e.g., he says his leg is weak, numb, etc. Alternative testing methods should be used to verify the objectivity of the abnormal findings, e.g., a seated straight-leg raising test in addition to a supine straight-leg raising test. Since abnormal findings may be intermittent, their continuous presence over a period of time must be established by a record of ongoing treatment. Neurological abnormalities may not completely subside after surgical or nonsurgical treatment, or with the passage of time. Residual neurological abnormalities, which persist after it has been determined clinically or by direct surgical or other observation that the ongoing or progressive condition is no longer present, cannot be considered to satisfy the required findings in 1.05C.

Where surgical procedures have been performed, documentation should include a copy of the operative note and available pathology reports.

Electrodiagnostic procedures and myelography may be useful in establishing the clinical diagnosis, but do not constitute alternative criteria to the requirements in 1.05C.

C. *After maximum benefit from surgical therapy* has been achieved in situations involving fractures of an upper extremity (see 1.12) or soft tissue injuries of a lower or upper extremity (see 1.13), i.e., there have been no significant changes in physical findings or X-ray findings for any 6-month period after the last definitive surgical procedure, evaluation should be made on the basis of demonstrable residuals.

D. *Major joints* as used herein refer to hip, knee, ankle, shoulder, elbow, or wrist and hand. (Wrist and hand are considered together as one major joint.)

E. *The measurements of joint motion* are based on the techniques described in the "Joint Motion Method of Measuring and Recording," published by the American Academy of Orthopedic Surgeons in 1965, or the "Guides to the Evaluation of Permanent Impairment—The Extremities and Back" (Chapter I); American Medical Association, 1971.

1.01 Category of Impairments, Musculoskeletal

1.02 Active rheumatoid arthritis and other inflammatory arthritis.

With both A and B.

A. History of persistent joint pain, swelling, and tenderness involving multiple major joints (see 1.00D) and with signs of joint inflammation (swelling and tenderness) on current physical examination despite prescribed therapy for at least 3 months, resulting in significant restriction of function of the affected joints, and clinical activity expected to last at least 12 months; and

B. Corroboration of diagnosis at some point in time by either.

1. Positive serologic test for rheumatoid factor; or

2. Antinuclear antibodies; or

3. Elevated sedimentation rate; or

4. Characteristic histologic changes in biopsy of synovial membrane or subcutaneous nodule (obtained independent of Social Security disability evaluation).

1.03 Arthritis of a major weight-bearing joint (due to any cause):

With history of persistent joint pain and stiffness with signs of marked limitation of motion or abnormal motion of the affected joint on current physical examination. With:

A. Gross anatomical deformity of hip or knee (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) supported by X-ray evidence of either significant joint space narrowing or significant bony destruc-

tion and markedly limiting ability to walk and stand; or

B. Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint and return to full weight-bearing status did not occur, or is not expected to occur, within 12 months of onset.

1.04 Arthritis of one major joint in each of the upper extremities (due to any cause):

With history of persistent joint pain and stiffness, signs of marked limitation of motion of the affected joints on current physical examination, and X-ray evidence of either significant joint space narrowing or significant bony destruction. With:

A. Abduction and forward flexion (elevation) of both arms at the shoulders, including scapular motion, restricted to less than 90 degrees; or

B. Gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability, ulnar deviation) and enlargement or effusion of the affected joints.

1.05 Disorders of the spine:

A. Arthritis manifested by ankylosis or fixation of the cervical or dorsolumbar spine at 30° or more of flexion measured from the neutral position, with X-ray evidence of:

1. Calcification of the anterior and lateral ligaments; or

2. Bilateral ankylosis of the sacroiliac joints with abnormal apophyseal articulations; or

B. Osteoporosis, generalized (established by X-ray) manifested by pain and limitation of back motion and paravertebral muscle spasm with X-ray evidence of either:

1. Compression fracture of a vertebral body with loss of at least 50 percent of the estimated height of the vertebral body prior to the compression fracture, with no intervening direct traumatic episode; or

2. Multiple fractures of vertebrae with no intervening direct traumatic episode; or

C. Other vertebrogenic disorders (e.g., herniated nucleus pulposus, spinal stenosis) with the following persisting for at least 3 months despite prescribed therapy and expected to last 12 months. With both 1 and 2:

1. Pain, muscle spasm, and significant limitation of motion in the spine; and

2. Appropriate radicular distribution of significant motor loss with muscle weakness and sensory and reflex loss.

1.08 Osteomyelitis or septic arthritis (established by X-ray):

A. Located in the pelvis, vertebra, femur, tibia, or a major joint of an upper or lower extremity, with persistent activity or occurrence of at least two episodes of acute activity within a 5-month period prior to adjudication, manifested by local inflammatory, and systemic signs and laboratory findings (e.g., heat, redness, swelling, leucocytosis, or increased sedimentation rate) and expected to last at least 12 months despite prescribed therapy; or

B. Multiple localizations and systemic manifestations as in A above.

1.09 Amputation or anatomical deformity of (i.e., loss of major function due to degenerative changes associated with vascular or neurological deficits, traumatic loss of muscle mass or tendons and X-ray evidence of bony ankylosis at an unfavorable angle, joint subluxation or instability):

- A. Both hands; or
- B. Both feet; or
- C. One hand and one foot.

1.10 Amputation of one lower extremity (at or above the tarsal region):

A. Hemipelvectomy or hip disarticulation; or

B. Amputation at or above the tarsal region due to peripheral vascular disease or diabetes mellitus; or

C. Inability to use a prosthesis effectively, without obligatory assistive devices, due to one of the following:

- 1. Vascular disease; or
- 2. Neurological complications (e.g., loss of position sense); or
- 3. Stump too short or stump complications persistent, or are expected to persist, for at least 12 months from onset; or
- 4. Disorder of contralateral lower extremity which markedly limits ability to walk and stand.

1.11 Fracture of the femur, tibia, tarsal bone of pelvis with solid union not evident on X-ray and not clinically solid, when such determination is feasible, and return to full weight-bearing status did not occur or is not expected to occur within 12 months of onset.

1.12 Fractures of an upper extremity with non-union of a fracture of the shaft of the humerus, radius, or ulna under continuing surgical management directed toward restoration of functional use of the extremity and such function was not restored or expected to be restored within 12 months after onset.

1.13 Soft tissue injuries of an upper or lower extremity requiring a series of staged surgical procedures within 12 months after onset for salvage and/or restoration of major function of the extremity, and such major function was not restored or expected to be restored within 12 months after onset.

2.00 SPECIAL SENSES AND SPEECH

A. Ophthalmology

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

2. Central visual acuity. A loss of central visual acuity may be caused by impaired distant and/or near vision. However, for an indi-

vidual to meet the level of severity described in 2.02 and 2.04, only the remaining central visual acuity for distance of the better eye with best correction based on the Snellen test chart measurement may be used. Correction obtained by special visual aids (e.g., contact lenses) will be considered if the individual has the ability to wear such aids.

3. Field of vision. Impairment of peripheral vision may result if there is contraction of the visual fields. The contraction may be either symmetrical or irregular. The extent of the remaining peripheral visual field will be determined by usual perimetric methods at a distance of 330 mm. under illumination of not less than 7-foot candles. For the phakic eye (the eye with a lens), a 3 mm. white disc target will be used, and for the aphakic eye (the eye without the lens), a 6 mm. white disc target will be used. In neither instance should corrective spectacle lenses be worn during the examination but if they have been used, this fact must be stated.

Measurements obtained on comparable perimetric devices may be used; this does not include the use of tangent screen measurements. For measurements obtained using the Goldmann perimeter, the object size designation III and the illumination designation 4 should be used for the phakic eye, and the object size designation IV and illumination designation 4 for the aphakic eye.

Field measurements must be accompanied by notated field charts, a description of the type and size of the target and the test distance. Tangent screen visual fields are not acceptable as a measurement of peripheral field loss.

Where the loss is predominantly in the lower visual fields, a system such as the weighted grid scale for perimetric fields described by B. Esterman (see Grid for Scoring Visual Fields, II. Perimeter, *Archives of Ophthalmology*, 79:400, 1968) may be used for determining whether the visual field loss is comparable to that described in Table 2.

4. Muscle function. Paralysis of the third cranial nerve producing ptosis, paralysis of accommodation, and dilation and immobility of the pupil may cause significant visual impairment. When all the muscle of the eye are paralyzed including the iris and ciliary body (total ophthalmoplegia), the condition is considered a severe impairment provided it is bilateral. A finding of severe impairment based primarily on impaired muscle function must be supported by a report of an actual measurement of ocular motility.

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

6. Special situations. Aphakia represents a visual handicap in addition to the loss of central visual acuity. The term monocular aphakia would apply to an individual who has had the lens removed from one eye, and who still retains the lens in his other eye, or to an individual who has only one eye which is aphakic. The term binocular aphakia would apply to an individual who has had both lenses removed. In cases of binocular aphakia, the central efficiency of the better eye will be accepted as 75 percent of its value. In cases of monocular aphakia, where the better eye is aphakic, the central visual efficiency will be accepted as 50 percent of the value. (If an individual has binocular aphakia, and the central visual acuity in the poorer eye can be corrected only to 20/200, or less, the central visual efficiency of the better eye will be accepted as 50 percent of its value.)

Ocular symptoms of systemic disease may or may not produce a disabling visual impairment. These manifestations should be evaluated as part of the underlying disease entity by reference to the particular body system involved.

7. Statutory blindness. The term "statutory blindness" refers to the degree of visual impairment which defines the term "blindness" in the Social Security Act. Both 2.02 and 2.03 A and B denote statutory blindness.

B. Otolaryngology

1. Hearing impairment. Hearing ability should be evaluated in terms of the person's ability to hear and distinguish speech.

Loss of hearing can be quantitatively determined by an audiometer which meets the standards of the American National Standards Institute (ANSI) for air and bone conducted stimuli (i.e., ANSI S 3.6-1969 and ANSI S 3.13-1972, or subsequent comparable revisions) and performing all hearing measurements in an environment which meets the ANSI standard for maximal permissible background sound (ANSI S 3.1-1977).

Speech discrimination should be determined using a standardized measure of speech discrimination ability in quiet at a test presentation level sufficient to ascertain maximum discrimination ability. The speech discrimination measure (test) used, and the level at which testing was done, must be reported.

Hearing tests should be preceded by an otolaryngologic examination and should be performed by or under the supervision of an otolaryngologist or audiologist qualified to perform such tests.

In order to establish an independent medical judgment as to the level of impairment in a claimant alleging deafness, the following examinations should be reported: Otolaryngologic examination, pure tone air and bone audiometry, speech reception threshold (SRT), and speech discrimination testing. A copy of reports of medical exam-

ination and audiologic evaluations must be submitted.

Cases of alleged "deaf mutism" should be documented by a hearing evaluation. Records obtained from a speech and hearing rehabilitation center or a special school for the deaf may be acceptable, but if these reports are not available, or are found to be inadequate, a current hearing evaluation should be submitted as outlined in the preceding paragraph.

2. Vertigo associated with disturbances of labyrinthine-vestibular function, including Meniere's disease. These disturbances of balance are characterized by a hallucination of motion or loss of position sense and a sensation of dizziness which may be constant or may occur in paroxysmal attacks. Nausea, vomiting, ataxia, and incapacitation are frequently observed, particularly during the acute attack. It is important to differentiate the report of rotary vertigo from that of "dizziness" which is described as lightheadedness, unsteadiness, confusion, or syncope.

Meniere's disease is characterized by paroxysmal attacks of vertigo, tinnitus, and fluctuating hearing loss. Remissions are unpredictable and irregular, but may be longstanding; hence, the severity of impairment is best determined after prolonged observation and serial reexaminations.

The diagnosis of a vestibular disorder requires a comprehensive neuro-otolaryngologic examination with a detailed description of the vertiginous episodes, including notation of frequency, severity, and duration of the attacks. Pure tone and speech audiometry with the appropriate special examinations, such as Bekesy audiometry, are necessary. Vestibular functions are assessed by positional and caloric testing, preferably by electronystagmography. When polytograms, contrast radiography, or other special tests have been performed, copies of the reports of these tests should be obtained in addition to reports of skull and temporal bone X-rays.

3. Organic loss of speech. Glossectomy or laryngectomy or cicatricial laryngeal stenosis due to injury or infection results in loss of voice production by normal means. In evaluating organic loss of speech (see 2.09), ability to produce speech by any means includes the use of mechanical or electronic devices. Impairment of speech due to neurologic disorders should be evaluated under 11.00-11.19.

2.01 Category of Impairments, Special Senses and Speech

2.02 Impairment of central visual acuity. Remaining vision in the better eye after best correction is 20/200 or less.

2.03 Contraction of peripheral visual fields in the better eye.

A. To 10° or less from the point of fixation; or

B. So the widest diameter subtends an angle no greater than 20°; or

C. To 20 percent or less visual field efficiency.

2.04 *Loss of visual efficiency.* Visual efficiency of better eye after best correction 20 percent or less. (The percent of remaining visual efficiency=the product of the percent of remaining central visual efficiency and the percent of remaining visual field efficiency.)

2.05 *Complete homonymous hemianopsia* (with or without macular sparing). Evaluate under 2.04.

2.06 *Total bilateral ophthalmoplegia.*

2.07 *Disturbance of labyrinthine-vestibular function (including Meniere's disease),* characterized by a history of frequent attacks of balance disturbance, tinnitus, and progressive loss of hearing. With both A and B:

A. Disturbed function of vestibular labyrinth demonstrated by caloric or other vestibular tests; and

B. Hearing loss established by audiometry.

2.08 *Hearing impairments* (hearing not restorable by a hearing aid) manifested by:

A. Average hearing threshold sensitivity for air conduction of 90 decibels or greater and for bone conduction to corresponding maximal levels, in the better ear, determined by the simple average of hearing threshold levels at 500, 1000 and 2000 Hz. (see 2.00B1); or

B. Speech discrimination scores of 40 percent or less in the better ear;

2.09 *Organic loss of speech* due to any cause with inability to produce by any means speech which can be heard, understood, and sustained.

TABLE NO. 1—PERCENTAGE OF CENTRAL VISUAL EFFICIENCY CORRESPONDING TO CENTRAL VISUAL ACUITY NOTATIONS FOR DISTANCE IN THE PHAKIC AND APHAKIC EYE (BETTER EYE)

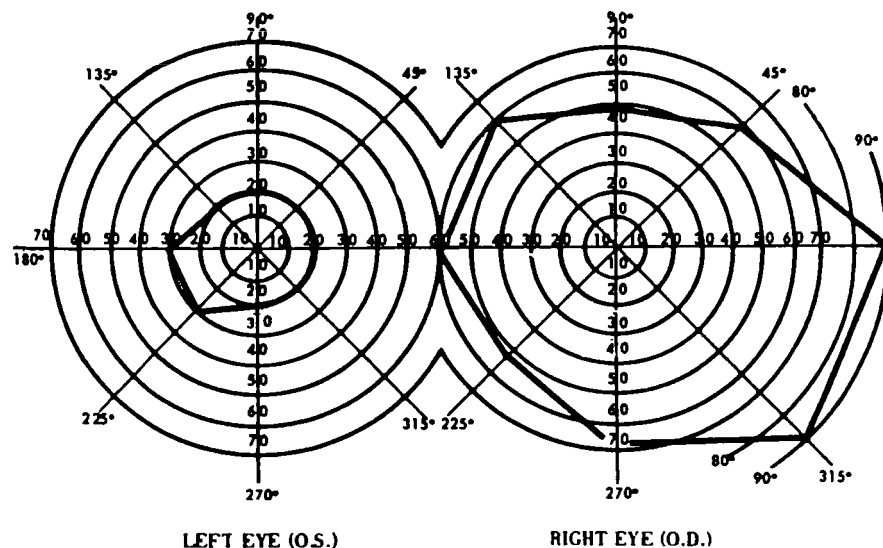
Snellen		Percent central visual efficiency		
English	Metric	Phakic ¹	Aphakic monocular ²	Aphakic binocular ³
20/16	6/5	100	50	75
20/20	6/8	100	50	75
20/25	6/7.5	95	47	71
20/32	6/10	90	45	67
20/40	6/12	85	42	64
20/50	6/15	75	37	58
20/64	6/20	65	32	49
20/80	6/24	60	30	45
20/100	6/30	50	25	37
20/125	6/38	40	20	30
20/160	6/48	30		22
20/200	6/60	20		

Column and Use.

¹Phakic.—1. A lens is present in both eyes. 2. A lens is present in the better eye and absent in the poorer eye. 3. A lens is present in one eye and the other eye is enucleated.

²Monocular.—1. A lens is absent in the better eye and present in the poorer eye. 2. The lenses are absent in both eyes; however, the central visual acuity in the poorer eye after best correction is 20/200 or less. 3. A lens is absent from one eye and the other eye is enucleated.

³Binocular.—1. The lenses are absent from both eyes and the central visual acuity in the poorer eye after best correction is greater than 20/200.



1. Diagram of right eye illustrates extent of normal visual field as tested on standard perimeter at 3/330 (3 mm. white disc at a distance of 330 mm.) under 7 foot-candles illumination. The sum of the eight principal meridians of this field total 500°.

2. The percent of visual field efficiency is obtained by adding the number of degrees of the eight principal meridians of the contracted field and dividing by 500. Diagram of left eye illustrates visual field contracted to 30° in the temporal and down and out meridians and to 20° in the remaining six meridians. The percent of visual field efficiency of this field is: $6 \times 20 + 2 \times 30 = 180 + 60 = 240$ or 48 percent remaining visual field efficiency, or 64 percent loss.

3.00 RESPIRATORY SYSTEM

A. *Introduction.* The listings in this section describe impairments resulting from respiratory disorders based on symptoms, physical signs, laboratory test abnormalities, and response to a regimen of treatment prescribed by a treating source. Respiratory disorders along with any associated impairment(s) must be established by medical evidence. Evidence must be provided in sufficient detail to permit an independent reviewer to evaluate the severity of the impairment.

Many individuals, especially those who have listing-level impairments, will have received

the benefit of medically prescribed treatment. Whenever there is evidence of such treatment, the longitudinal clinical record must include a description of the treatment prescribed by the treating source and response in addition to information about the nature and severity of the impairment. It is important to document any prescribed treatment and response, because this medical management may have improved the individual's functional status. The longitudinal record should provide information regarding functional recovery, if any.

Some individuals will not have received ongoing treatment or have an ongoing relationship with the medical community, despite the existence of a severe impairment(s). An individual who does not receive treatment may or may not be able to show the existence of an impairment that meets the criteria of these listings. Even if an individual does not show that his or her impairment meets the criteria of these listings, the individual may have an impairment(s) equivalent in severity to one of the listed impairments or be disabled because of a limited residual functional capacity. Unless the claim can be decided favorably on the basis of the current evidence, a longitudinal record is still important because it will provide information about such things as the ongoing medical severity of the impairment, the level of the individual's

functioning, and the frequency, severity, and duration of symptoms. Also, the asthma listing specifically includes a requirement for continuing signs and symptoms despite a regimen of prescribed treatment.

Impairments caused by chronic disorders of the respiratory system generally produce irreversible loss of pulmonary function due to ventilatory impairments, gas exchange abnormalities, or a combination of both. The most common symptoms attributable to these disorders are dyspnea on exertion, cough, wheezing, sputum production, hemoptysis, and chest pain. Because these symptoms are common to many other diseases, a thorough medical history, physical examination, and chest x-ray or other appropriate imaging technique are required to establish chronic pulmonary disease. Pulmonary function testing is required to assess the severity of the respiratory impairment once a disease process is established by appropriate clinical and laboratory findings.

Alterations of pulmonary function can be due to obstructive airway disease (e.g., emphysema, chronic bronchitis, asthma), restrictive pulmonary disorders with primary loss of lung volume (e.g., pulmonary resection, thoracoplasty, chest cage deformity as in kyphoscoliosis or obesity), or infiltrative interstitial disorders (e.g., diffuse pulmonary fibrosis). Gas exchange abnormalities without significant airway obstruction can be produced by interstitial disorders. Disorders involving the pulmonary circulation (e.g., primary pulmonary hypertension, recurrent thromboembolic disease, primary or secondary pulmonary vasculitis) can produce pulmonary vascular hypertension and, eventually, pulmonary heart disease (cor pulmonale) and right heart failure. Persistent hypoxemia produced by any chronic pulmonary disorder also can result in chronic pulmonary hypertension and right heart failure. Chronic infection, caused most frequently by mycobacterial or mycotic organisms, can produce extensive and progressive lung destruction resulting in marked loss of pulmonary function. Some disorders, such as bronchiectasis, cystic fibrosis, and asthma, can be associated with intermittent exacerbations of such frequency and intensity that they produce a disabling impairment, even when pulmonary function during periods of relative clinical stability is relatively well-maintained.

Respiratory impairments usually can be evaluated under these listings on the basis of a complete medical history, physical examination, a chest x-ray or other appropriate imaging techniques, and spirometric pulmonary function tests. In some situations, most typically with a diagnosis of diffuse interstitial fibrosis or clinical findings suggesting cor pulmonale, such as cyanosis or secondary polycythemia, an impairment may be underestimated on the basis of

spirometry alone. More sophisticated pulmonary function testing may then be necessary to determine if gas exchange abnormalities contribute to the severity of a respiratory impairment. Additional testing might include measurement of diffusing capacity of the lungs for carbon monoxide or resting arterial blood gases. Measurement of arterial blood gases during exercise is required infrequently. In disorders of the pulmonary circulation, right heart catheterization with angiography and/or direct measurement of pulmonary artery pressure may have been done to establish a diagnosis and evaluate severity. When performed, the results of the procedure should be obtained. Cardiac catheterization will not be purchased.

These listings are examples of common respiratory disorders that are severe enough to prevent a person from engaging in any gainful activity. When an individual has a medically determinable impairment that is not listed, an impairment which does not meet a listing, or a combination of impairments no one of which meets a listing, we will consider whether the individual's impairment or combination of impairments is medically equivalent in severity to a listed impairment. Individuals who have an impairment(s) with a level of severity which does not meet or equal the criteria of the listings may or may not have the residual functional capacity (RFC) which would enable them to engage in substantial gainful activity. Evaluation of the impairment(s) of these individuals will proceed through the final steps of the sequential evaluation process.

B. Mycobacterial, mycotic, and other chronic persistent infections of the lung. These disorders are evaluated on the basis of the resulting limitations in pulmonary function. Evidence of chronic infections, such as active mycobacterial diseases or mycoses with positive cultures, drug resistance, enlarging parenchymal lesions, or cavitation, is not, by itself, a basis for determining that an individual has a disabling impairment expected to last 12 months. In those unusual cases of pulmonary infection that persist for a period approaching 12 consecutive months, the clinical findings, complications, therapeutic considerations, and prognosis must be carefully assessed to determine whether, despite relatively well-maintained pulmonary function, the individual nevertheless has an impairment that is expected to last for at least 12 consecutive months and prevent gainful activity.

C. Episodic respiratory disease. When a respiratory impairment is episodic in nature, as can occur with exacerbations of asthma, cystic fibrosis, bronchiectasis, or chronic

asthmatic bronchitis, the frequency and intensity of episodes that occur despite prescribed treatment are often the major criteria for determining the level of impairment. Documentation for these exacerbations should include available hospital, emergency facility and/or physician records indicating the dates of treatment; clinical and laboratory findings on presentation, such as the results of spirometry and arterial blood gas studies (ABGS); the treatment administered; the time period required for treatment; and the clinical response. Attacks of asthma, episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum), or respiratory failure as referred to in paragraph B of 3.03, 3.04, and 3.07, are defined as prolonged symptomatic episodes lasting one or more days and requiring intensive treatment, such as intravenous bronchodilator or antibiotic administration or prolonged inhalational bronchodilator therapy in a hospital, emergency room or equivalent setting. Hospital admissions are defined as inpatient hospitalizations for longer than 24 hours. The medical evidence must also include information documenting adherence to a prescribed regimen of treatment as well as a description of physical signs. For asthma, the medical evidence should include spirometric results obtained between attacks that document the presence of baseline airflow obstruction.

D. Cystic fibrosis is a disorder that affects either the respiratory or digestive body systems or both and is responsible for a wide and variable spectrum of clinical manifestations and complications. Confirmation of the diagnosis is based upon an elevated sweat sodium concentration or chloride concentration accompanied by one or more of the following: the presence of chronic obstructive pulmonary disease, insufficiency of exocrine pancreatic function, meconium ileus, or a positive family history. The quantitative pilocarpine iontophoresis procedure for collection of sweat content must be utilized. Two methods are acceptable: the "Procedure for the Quantitative Iontophoretic Sweat Test for Cystic Fibrosis" published by the Cystic Fibrosis Foundation and contained in, "A Test for Concentration of Electrolytes in Sweat in Cystic Fibrosis of the Pancreas Utilizing Pilocarpine Iontophoresis," Gibson, I.E., and Cooke, R.E., *Pediatrics*, Vol. 23: 645, 1959; or the "Wescor Macroduct System." To establish the diagnosis of cystic fibrosis, the sweat sodium or chloride content must be analyzed quantitatively using an acceptable laboratory technique. Another diagnostic test is the "CF gene mutation analysis" for homozygosity of the cystic fibrosis gene. The pulmonary manifestations of this disorder should be evaluated under 3.04. The nonpulmonary aspects of cystic fibrosis should be evaluated under the digestive body system (5.00). Because cystic fibrosis may involve

the respiratory and digestive body systems, the combined effects of the involvement of these body systems must be considered in case adjudication.

E. Documentation of pulmonary function testing. The results of spirometry that are used for adjudication under paragraphs A and B of 3.02 and paragraph A of 3.04 should be expressed in liters (L), body temperature and pressure saturated with water vapor (BTPS). The reported one-second forced expiratory volume (FEV₁) and forced vital capacity (FVC) should represent the largest of at least three satisfactory forced expiratory maneuvers. Two of the satisfactory spirometers should be reproducible for both pre-bronchodilator tests and, if indicated, post-bronchodilator tests. A value is considered reproducible if it does not differ from the largest value by more than 5 percent or 0.1 L, whichever is greater. The highest values of the FEV₁ and FVC, whether from the same or different tracings, should be used to assess the severity of the respiratory impairment. Peak flow should be achieved early in expiration, and the spirogram should have a smooth contour with gradually decreasing flow throughout expiration. The zero time for measurement of the FEV₁ and FVC, if not distinct, should be derived by linear back-extrapolation of peak flow to zero volume. A spirogram is satisfactory for measurement of the FEV₁ if the expiratory volume at the back-extrapolated zero time is less than 5 percent of the FVC or 0.1 L, whichever is greater. The spirogram is satisfactory for measurement of the FVC if maximal expiratory effort continues for at least 6 seconds, or if there is a plateau in the volume-time curve with no detectable change in expired volume (VE) during the last 2 seconds of maximal expiratory effort.

Spirometry should be repeated after administration of an aerosolized bronchodilator under supervision of the testing personnel if the pre-bronchodilator FEV₁ value is less than 70 percent of the predicted normal value. Pulmonary function studies should not be performed unless the clinical status is stable (e.g., the individual is not having an asthmatic attack or suffering from an acute respiratory infection or other chronic illness). Wheezing is common in asthma, chronic bronchitis, or chronic obstructive pulmonary disease and does not preclude testing. The effect of the administered bronchodilator in relieving bronchospasm and improving ventilatory function is assessed by spirometry. If a bronchodilator is not administered, the reason should be clearly stated in the report. Pulmonary function studies performed to assess airflow obstruction without testing after bronchodilators cannot be used to assess levels of impairment in the range that prevents any gainful work activity, unless the use of bronchodilators is contraindicated. Post-

bronchodilator testing should be performed 10 minutes after bronchodilator administration. The dose and name of the bronchodilator administered should be specified. The values in paragraphs A and B of 3.02 must only be used as criteria for the level of ventilatory impairment that exists during the individual's most stable state of health (i.e., any period in time except during or shortly after an exacerbation).

The appropriately labeled spirometric tracing, showing the claimant's name, date of testing, distance per second on the abscissa and distance per liter (L) on the ordinate, must be incorporated into the file. The manufacturer and model number of the device used to measure and record the spirogram should be stated. The testing device must accurately measure both time and volume, the latter to within 1 percent of a 3 L calibrating volume. If the spirogram was generated by any means other than direct pen linkage to a mechanical displacement-type spirometer, the spirometric tracing must show a recorded calibration of volume units using a mechanical volume input such as a 3 L syringe.

If the spirometer directly measures flow, and volume is derived by electronic integration, the linearity of the device must be documented by recording volume calibrations at three different flow rates of approximately 30 L/min (3 L/6 sec), 60 L/min (3 L/3 sec), and 180 L/min (3 L/sec). The volume calibrations should agree to within 1 percent of a 3 L calibrating volume. The proximity of the flow sensor to the individual should be noted, and it should be stated whether or not a BTPS correction factor was used for the calibration recordings and for the individual's actual spiograms.

The spirogram must be recorded at a speed of at least 20 mm/sec, and the recording device must provide a volume excursion of at least 10 mm/L. If reproductions of the original spirometric tracings are submitted, they must be legible and have a time scale of at least 20 mm/sec and a volume scale of at least 10 mm/L to permit independent measurements. Calculation of FEV₁ from a flow-volume tracing is not acceptable, i.e., the spirogram and calibrations must be presented in a volume-time format at a speed of at least 20 mm/sec and a volume excursion of at least 10 mm/L to permit independent evaluation.

A statement should be made in the pulmonary function test report of the individual's ability to understand directions as well as his or her effort and cooperation in performing the pulmonary function tests.

The pulmonary function tables in 3.02 and 3.04 are based on measurement of standing height without shoes. If an individual has marked spinal deformities (e.g., kyphoscoliosis), the measured span between the fingertips with the upper extremities ab-

ducted 90 degrees should be substituted for height when this measurement is greater than the standing height without shoes.

F. Documentation of chronic impairment of gas exchange.

1. *Diffusing capacity of the lungs for carbon monoxide (DLCO).* A diffusing capacity of the lungs for carbon monoxide study should be purchased in cases in which there is documentation of chronic pulmonary disease, but the existing evidence, including properly performed spirometry, is not adequate to establish the level of functional impairment. Before purchasing DLCO measurements, the medical history, physical examination, reports of chest x-ray or other appropriate imaging techniques, and spirometric test results must be obtained and reviewed because favorable decisions can often be made based on available evidence without the need for DLCO studies. Purchase of a DLCO study may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided.

The DLCO should be measured by the single breath technique with the individual relaxed and seated. At sea level, the inspired gas mixture should contain approximately 0.3 percent carbon monoxide (CO), 10 percent helium (He), 21 percent oxygen (O₂), and the balance nitrogen. At altitudes above sea level, the inspired O₂ concentration may be raised to provide an inspired O₂ tension of approximately 150 mm Hg. Alternatively, the sea level mixture may be employed at altitude and the measured DLCO corrected for ambient barometric pressure. Helium may be replaced by another inert gas at an appropriate concentration. The inspired volume (VI) during the DLCO maneuver should be at least 90 percent of the previously determined vital capacity (VC). The inspiratory time for the VI should be less than 2 seconds, and the breath-hold time should be between 9 and 11 seconds. The washout volume should be between 0.75 and 1.00 L, unless the VC is less than 2 L. In this case, the washout volume may be reduced to 0.50 L; any such change should be noted in the report. The alveolar sample volume should be between 0.5 and 1.0 L and be collected in less than 3 seconds. At least 4 minutes should be allowed for gas washout between repeat studies.

A DLCO should be reported in units of ml CO, standard temperature, pressure, dry (STPD)/min/mm Hg uncorrected for hemoglobin concentration and be based on a single-breath alveolar volume determination. Abnormal hemoglobin or hematocrit values, and/or carboxyhemoglobin levels should be reported along with diffusing capacity.

The DLCO value used for adjudication should represent the mean of at least two acceptable measurements, as defined above. In addition, two acceptable tests should be within 10 percent of each other or 3 ml

CO(STPD)/min/mm Hg, whichever is larger. The percent difference should be calculated as $100 \times (\text{test 1} - \text{test 2}) / \text{average DLCO}$.

The ability of the individual to follow directions and perform the test properly should be described in the written report. The report should include tracings of the VI, breath-hold maneuver, and VE appropriately labeled with the name of the individual and the date of the test. The time axis should be at least 20 mm/sec and the volume axis at least 10 mm/L. The percentage concentrations of inspired O₂, and inspired and expired CO and He for each of the maneuvers should be provided, and the algorithm used to calculate test results noted. Sufficient data must be provided to permit independent calculation of results (and, if necessary, calculation of corrections for anemia and/or carboxyhemoglobin).

2. *Arterial blood gas studies (ABGS).* An ABGS performed at rest (while breathing room air, awake and sitting or standing) or during exercise should be analyzed in a laboratory certified by a State or Federal agency. If the laboratory is not certified, it must submit evidence of participation in a national proficiency testing program as well as acceptable quality control at the time of testing. The report should include the altitude of the facility and the barometric pressure on the date of analysis.

Purchase of resting ABGS may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided. If the results of a DLCO study are greater than 40 percent of predicted normal but less than 60 percent of predicted normal, purchase of resting ABGS should be considered. Before purchasing resting ABGS, a program physician, preferably one experienced in the care of patients with pulmonary disease, must review all clinical and laboratory data short of this procedure, including spirometry, to determine whether obtaining the test would present a significant risk to the individual.

3. *Exercise testing.* Exercise testing with measurement of arterial blood gases during exercise may be appropriate in cases in which there is documentation of chronic pulmonary disease, but full development, short of exercise testing, is not adequate to establish if the impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided. In this context, "full development" means that results from spirometry and measurement of DLCO and resting ABGS have been obtained from treating sources or through purchase. Exercise arterial blood gas measurements will be required infrequently and should be purchased only after careful review of the medical history, physical examination, chest x-ray or other appropriate imaging techniques, spirometry, DLCO, electrocardiogram (ECG),

hematocrit or hemoglobin, and resting blood gas results by a program physician, preferably one experienced in the care of patients with pulmonary disease, to determine whether obtaining the test would present a significant risk to the individual. Oximetry and capillary blood gas analysis are not acceptable substitutes for the measurement of arterial blood gases. Arterial blood gas samples obtained after the completion of exercise are not acceptable for establishing an individual's functional capacity.

Generally, individuals with a DLCO greater than 60 percent of predicted normal would not be considered for exercise testing with measurement of blood gas studies. The exercise test facility must be provided with the claimant's clinical records, reports of chest x-ray or other appropriate imaging techniques, and any spirometry, DLCO, and resting blood gas results obtained as evidence of record. The testing facility must determine whether exercise testing present a significant risk to the individual; if it does, the reason for not performing the test must be reported in writing.

4. *Methodology.* Individuals considered for exercise testing first should have resting arterial blood partial pressure of oxygen (PO₂), resting arterial blood partial pressure of carbon dioxide (PCO₂) and negative log of hydrogen ion concentration (pH) determinations by the testing facility. The sample should be obtained in either the sitting or standing position. The individual should then perform exercise under steady state conditions, preferably on a treadmill, breathing room air, for a period of 4 to 6 minutes at a speed and grade providing an oxygen consumption of approximately 17.5 ml/kg/min (5 METs). If a bicycle ergometer is used, an exercise equivalent of 5 METs (e.g., 450 kpm/min, or 75 watts, for a 176 pound (80 kilogram) person) should be used. If the individual is able to complete this level of exercise without achieving listing-level hypoxemia, then he or she should be exercised at higher workloads to determine exercise capacity. A warm-up period of treadmill walking or cycling may be performed to acquaint the individual with the exercise procedure. If during the warm-up period the individual cannot achieve an exercise level of 5 METs, a lower workload may be selected in keeping with the estimate of exercise capacity. The individual should be monitored by ECG throughout the exercise and in the immediate post-exercise period. Blood pressure and an ECG should be recorded during each minute of exercise. During the final 2 minutes of a specific level of steady state exercise, an arterial blood sample should be drawn and analyzed for oxygen pressure (or tension) (PO₂), carbon dioxide pressure (or tension) (PCO₂), and pH. At the discretion of the testing facility, the

sample may be obtained either from an indwelling arterial catheter or by direct arterial puncture. If possible, in order to evaluate exercise capacity more accurately, a test site should be selected that has the capability to measure minute ventilation, O₂ consumption, and carbon dioxide (CO₂) production. If the claimant fails to complete 4 to 6 minutes of steady state exercise, the testing laboratory should comment on the reason and report the actual duration and levels of exercise performed. This comment is necessary to determine if the individual's test performance was limited by lack of effort or other impairment (e.g., cardiac, peripheral vascular, musculoskeletal, neurological).

The exercise test report should contain representative ECG strips taken before, during and after exercise; resting and exercise arterial blood gas values; treadmill speed and grade settings, or, if a bicycle ergometer was used, exercise levels expressed in watts or kpm/min; and the duration of exercise. Body weight also should be recorded. If measured, O₂ consumption (STPD), minute ventilation (BTPS), and CO₂ production (STPD) also should be reported. The altitude of the test site, its normal range of blood gas values, and the barometric pressure on the test date must be noted.

G. Chronic cor pulmonale and pulmonary vascular disease.

The establishment of an impairment attributable to irreversible cor pulmonale secondary to chronic pulmonary hypertension requires documentation by signs and laboratory findings of right ventricular overload or failure (e.g., an early diastolic right-sided gallop on auscultation, neck vein distension, hepatomegaly, peripheral edema, right ventricular outflow tract enlargement on x-ray or other appropriate imaging techniques, right ventricular hypertrophy on ECG, and increased pulmonary artery pressure measured by right heart catheterization available from treating sources). Cardiac catheterization will not be purchased. Because hypoxemia may accompany heart failure and is also a cause of pulmonary hypertension, and may be associated with hypoventilation and respiratory acidosis, arterial blood gases may demonstrate hypoxemia (decreased PO₂), CO₂ retention (increased PCO₂), and acidosis (decreased pH). Polycythemia with an elevated red blood cell count and hematocrit may be found in the presence of chronic hypoxemia.

P-pulmonale on the ECG does not establish chronic pulmonary hypertension or chronic cor pulmonale. Evidence of florid right heart failure need not be present at the time of adjudication for a listing (e.g., 3.09) to be satisfied, but the medical evidence of record should establish that cor pulmonale is chronic and irreversible.

H. Sleep-related breathing disorders.

Sleep-related breathing disorders (sleep apneas) are caused by periodic cessation of respiration associated with hypoxemia and frequent arousals from sleep. Although many individuals with one of these disorders will respond to prescribed treatment, in some, the disturbed sleep pattern and associated chronic nocturnal hypoxemia cause daytime sleepiness with chronic pulmonary hypertension and/or disturbances in cognitive function. Because daytime sleepiness can affect memory, orientation, and personality, a longitudinal treatment record may be needed to evaluate mental functioning. Not all individuals with sleep apnea develop a functional impairment that affects work activity. When any gainful work is precluded, the physiologic basis for the impairment may be chronic cor pulmonale. Chronic hypoxemia due to episodic apnea may cause pulmonary hypertension (see 3.00G and 3.09). Daytime somnolence may be associated with disturbance in cognitive function. Impairment of cognitive function may be evaluated under organic mental disorders (12.02). If the disorder is associated with gross obesity, it should be evaluated under the applicable obesity listing.

3.01 Category of Impairments, Respiratory System.

3.02 Chronic pulmonary insufficiency.

A. Chronic obstructive pulmonary disease, due to any cause, with the FEV₁ equal to or less than the values specified in table I corresponding to the person's height without shoes. (In cases of marked spinal deformity, see 3.00E.);

TABLE I

Height without shoes (centimeters)	Height without shoes (inches)	FEV ₁ , equal to or less than (L BTPS)
154 or less	60 or less	1.06
155-160	61-63	1.15
161-165	64-65	1.25
166-170	66-67	1.35
171-175	68-69	1.45
176-180	70-71	1.55
181 or more	72 or more	1.65

Or

B. Chronic restrictive ventilatory disease, due to any cause, with the FVC equal to or less than the values specified in Table II corresponding to the person's height without shoes. (In cases of marked spinal deformity, see 3.00E.);

TABLE II

Height without shoes (centimeters)	Height without shoes (inches)	FVC equal to or less than (L BTPS)
154 or less	60 or less	1.25
155-160	61-63	1.35
161-165	64-65	1.45
166-170	66-67	1.55
171-175	68-69	1.65
176-180	70-71	1.75
181 or more	72 or more	1.85

Or

C. Chronic impairment of gas exchange due to clinically documented pulmonary disease. With:

1. Single breath DLCO (see 3.00F1) less than 10.5 ml/min/mm Hg or less than 40 percent of the predicted normal value. (Predicted values must either be based on data obtained at the test site or published values from a laboratory using the same technique as the test site. The source of the predicted values should be reported. If they are not published, they should be submitted in the form of a table or nomogram); or

2. Arterial blood gas values of PO₂ and simultaneously determined PCO₂ measured while at rest (breathing room air, awake and sitting or standing) in a clinically stable condition on at least two occasions, three or more weeks apart within a 6-month period, equal to or less than the values specified in the applicable table III-A or III-B or III-C:

TABLE III.—A

[Applicable at test sites less than 3,000 feet above sea level]

Arterial PCO ₂ (mm. Hg) and	Arterial PO ₂ equal to or less than (mm. Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

TABLE III.—B

[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO ₂ (mm. Hg) and	Arterial PO ₂ equal to or less than (mm. Hg)
30 or below	60
31	59
32	58
33	57
34	56

TABLE III.—B—Continued
[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO ₂ (mm. Hg) and	Arterial PO ₂ equal to or less than (mm. Hg)
35	55
36	54
37	53
38	52
39	51
40 or above	50

TABLE III.—C

[Applicable at test sites over 6,000 feet above sea level]

Arterial PCO ₂ (mm. Hg) and	Arterial PO ₂ or equal to or less than (mm. Hg)
30 or below	55
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

Or

3. Arterial blood gas values of PO₂ and simultaneously determined PCO₂ during steady state exercise breathing room air (level of exercise equivalent to or less than 17.5 ml O₂ consumption/kg/min or 5 METs) equal to or less than the values specified in the applicable table III-A or III-B or III-C in 3.02C2.

3.03 Asthma. With:

A. Chronic asthmatic bronchitis. Evaluate under the criteria for chronic obstructive pulmonary disease in 3.02A;

Or

B. Attacks (as defined in 3.00C), in spite of prescribed treatment and requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each in-patient hospitalization for longer than 24 hours for control of asthma counts as two attacks, and an evaluation period of at least 12 consecutive months must be used to determine the frequency of attacks.

3.04 Cystic fibrosis. With:

A. An FEV₁ equal to or less than the appropriate value specified in table IV corresponding to the individual's height without shoes. (In cases of marked spinal deformity, see 3.00E.);

Or

B. Episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum) or respiratory failure (documented according to 3.00C), requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each inpatient hospitalization for longer than 24 hours for treatment counts as two episodes, and an evaluation period of at least 12 consecutive months must be used to determine the frequency of episodes;

Or

C. Persistent pulmonary infection accompanied by superimposed, recurrent, symptomatic episodes of increased bacterial infection occurring at least once every 6 months and requiring intravenous or nebulization antimicrobial therapy.

TABLE IV

[Applicable only for evaluation under 3.04A—cystic fibrosis]

Height without shoes (centimeters)	Height without shoes (inches)	FEV ₁ , equal to or less than (L BTPS)
154 or less	60 or less	1.45
155-159	61-62	1.55
160-164	63-64	1.65
165-169	65-66	1.75
170-174	67-68	1.85
175-179	69-70	1.95
180 or more	71 or more	2.05

3.05 [Reserved]

3.06 *Pneumoconiosis* (demonstrated by appropriate imaging techniques). Evaluate under the appropriate criteria in 3.02.

3.07 *Bronchiectasis* (demonstrated by appropriate imaging techniques). With:

A. Impairment of pulmonary function due to extensive disease. Evaluate under the appropriate criteria in 3.02;

Or

B. Episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum) or respiratory failure (documented according to 3.00C), requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each inpatient hospitalization for longer than 24 hours for treatment counts as two episodes, and an evaluation of at least 12 consecutive months must be used to determine the frequency of episodes.

3.08 *Mycobacterial, mycotic, and other chronic persistent infections of the lung* (see 3.00B). Evaluate under the appropriate criteria in 3.02.

3.09 *Cor pulmonale secondary to chronic pulmonary vascular hypertension*. Clinical evidence of cor pulmonale (documented according to 3.00G) with:

A. Mean pulmonary artery pressure greater than 40 mm Hg;

Or

B. Arterial hypoxemia. Evaluate under the criteria in 3.02C;

Or

C. Evaluate under the applicable criteria in 4.02.

3.10 *Sleep-related breathing disorders*. Evaluate under 3.09 (chronic cor pulmonale), 9.09 (obesity), or 12.02 (organic mental disorders).

4.00 Cardiovascular System

A. *Introduction*. The listings in this section describe impairments resulting from cardiovascular disease based on symptoms, physical signs, laboratory test abnormalities, and response to a regimen of therapy prescribed by a treating source. A longitudinal clinical record covering a period of not less than 3 months of observations and therapy is usually necessary for the assessment of severity and expected duration of cardiovascular impairment, unless the claim can be decided favorably on the basis of the current evidence. All relevant evidence must be considered in assessing disability.

Many individuals, especially those who have listing-level impairments, will have received the benefit of medically prescribed treatment. Whenever there is evidence of such treatment, the longitudinal clinical record must include a description of the therapy prescribed by the treating source and response, in addition to information about the nature and severity of the impairment. It is important to document any prescribed therapy and response because this medical management may have improved the individual's functional status. The longitudinal record should provide information regarding functional recovery, if any.

Some individuals will not have received ongoing treatment or have an ongoing relationship with the medical community despite the existence of a severe impairment(s). Unless the claim can be decided favorably on the basis of the current evidence, a longitudinal record is still important because it will provide information about such things as the ongoing medical severity of the impairment, the degree of recovery from cardiac insult, the level of the individual's functioning, and the frequency, severity, and duration of symptoms. Also, several listings include a requirement for continuing signs and symptoms despite a regimen of prescribed treatment. Even though an individual who does not receive treatment may not be able to show an impairment that meets the criteria of these listings, the individual may have an impairment(s) equivalent in severity to one

Social Security Administration

of the listed impairments or be disabled because of a limited residual functional capacity.

Indeed, it must be remembered that these listings are only examples of common cardiovascular disorders that are severe enough to prevent a person from engaging in gainful activity. Therefore, in any case in which an individual has a medically determinable impairment that is not listed, or a combination of impairments no one of which meets a listing, we will make a medical equivalence determination. Individuals who have an impairment(s) with a level of severity which does not meet or equal the criteria of the cardiovascular listings may or may not have the residual functional capacity (RFC) which would enable them to engage in substantial gainful activity. Evaluation of the impairment(s) of these individuals should proceed through the final steps of the sequential evaluation process (or, as appropriate, the steps in the medical improvement review standard).

B. *Cardiovascular impairment* results from one or more of four consequences of heart disease:

1. Chronic heart failure or ventricular dysfunction.

2. Discomfort or pain due to myocardial ischemia, with or without necrosis of heart muscle.

3. Syncope, or near syncope, due to inadequate cerebral perfusion from any cardiac cause such as obstruction of flow or disturbance in rhythm or conduction resulting in inadequate cardiac output.

4. Central cyanosis due to right-to-left shunt, arterial desaturation, or pulmonary vascular disease.

Impairment from diseases of arteries and veins may result from disorders of the vasculature in the central nervous system (11.04A, B), eyes (2.02-2.04), kidney (6.02), and other organs.

C. *Documentation*. Each individual's file must include sufficiently detailed reports on history, physical examinations, laboratory studies, and any prescribed therapy and response to allow an independent reviewer to assess the severity and duration of the cardiovascular impairment.

1. *Electrocardiography*

a. An original or legible copy of the 12-lead electrocardiogram (ECG) obtained at rest must be submitted, appropriately dated and labeled, with the standardization inscribed on the tracing. Alteration in standardization of specific leads (such as to accommodate large QRS amplitudes) must be identified on those leads.

(1) Detailed descriptions or computer-averaged signals without original or legible copies of the ECG as described in subsection 4.00Cia are not acceptable.

(2) The effects of drugs or electrolyte abnormalities must be considered as possible noncoronary causes of ECG abnormalities of ventricular repolarization, i.e., those involving the ST segment and T wave. If available, the predrug (especially digitalis glycoside) ECG should be submitted.

(3) The term "ischemic" is used in 4.04A to describe an abnormal ST segment deviation. Nonspecific repolarization abnormalities should not be confused with "ischemic" changes.

b. ECGs obtained in conjunction with treadmill, bicycle, or arm exercise tests should meet the following specifications:

(1) ECGs must include the original calibrated ECG tracings or a legible copy.

(2) A 12-lead baseline ECG must be recorded in the upright position before exercise.

(3) A 12-lead ECG should be recorded at the end of each minute of exercise, including at the time the ST segment abnormalities reach or exceed the criteria for abnormality described in 4.04A or the individual experiences chest discomfort or other abnormalities, and also when the exercise test is terminated.

(4) If ECG documentation of the effects of hyperventilation is obtained, the exercise test should be deferred for at least 10 minutes because metabolic changes of hyperventilation may alter the physiologic and ECG response to exercise.

(5) Post-exercise ECGs should be recorded using a generally accepted protocol consistent with the prevailing state of medical knowledge and clinical practice.

(6) All resting, exercise, and recovery ECG strips must have a standardization inscribed on the tracing. The ECG strips should be labeled to indicate the times recorded and the relationship to the stage of the exercise protocol. The speed and grade (treadmill test) or work rate (bicycle or arm ergometric test) should be recorded. The highest level of exercise achieved, blood pressure levels during testing, and the reason(s) for terminating the test (including limiting signs or symptoms) must be recorded.

2. *Purchasing Exercise Tests*

a. It is well recognized by medical experts that exercise testing is the best tool currently available for estimating maximal aerobic capacity in individuals with cardiovascular impairments. Purchase of an exercise test may be appropriate when there is a question whether an impairment meets or is equivalent in severity to one of the listings, or when there is insufficient evidence in the record to evaluate aerobic capacity, and the claim cannot otherwise be favorably decided. Before purchasing an exercise test, a program physician, preferably one with experience in the care of patients with cardiovascular disease, must review the pertinent

history, physical examinations, and laboratory tests to determine whether obtaining the test would present a significant risk to the individual (see 4.00C2c). Purchase may be indicated when there is no significant risk to exercise testing and there is no timely test of record. An exercise test is generally considered timely for 12 months after the date performed, provided there has been no change in clinical status that may alter the severity of the cardiac impairment.

b. Methodology.

(1) When an exercise test is purchased, it should be a "sign-or symptom-limited" test characterized by a progressive multistage regimen. A purchased exercise test must be performed using a generally accepted protocol consistent with the prevailing state of medical knowledge and clinical practice. A description of the protocol that was followed must be provided, and the test must meet the requirements of 4.00C1b and this section. A pre-exercise posthyperventilation tracing may be essential for the proper evaluation of an "abnormal" test in certain circumstances, such as in women with evidence of mitral valve prolapse.

(2) The exercise test should be paced to the capabilities of the individual and be supervised by a physician. With a treadmill test, the speed, grade (incline) and duration of exercise must be recorded for each exercise test stage performed. Other exercise test protocols or techniques that are used should utilize similar workloads.

(3) Levels of exercise should be described in terms of workload and duration of each stage, e.g., treadmill speed and grade, or bicycle ergometer work rate in kpm/min or watts.

(4) Normally, systolic blood pressure and heart rate increase gradually with exercise. A decrease in systolic blood pressure during exercise below the usual resting level is often associated with ischemia-induced left ventricular dysfunction resulting in decreased cardiac output. Some individuals (because of deconditioning or apprehension) with increased sympathetic responses may increase their systolic blood pressure and heart rate above their usual resting level just before and early into exercise. This occurrence may limit the ability to assess the significance of an early decrease in systolic blood pressure and heart rate if exercise is discontinued shortly after initiation. In addition, isolated systolic hypertension may be a manifestation of arteriosclerosis.

(5) The exercise laboratory's physical environment, staffing, and equipment should meet the generally accepted standards for adult exercise test laboratories.

c. Risk factors in exercise testing. The following are examples of situations in which exercise testing will not be purchased: unstable progressive angina pectoris, a history of acute myocardial infarction within the past

3 months, New York Heart Association (NYHA) class IV heart failure, cardiac drug toxicity, uncontrolled serious arrhythmia (including uncontrolled atrial fibrillation, Mobitz II, and third-degree block), Wolff-Parkinson-White syndrome, uncontrolled severe systemic arterial hypertension, marked pulmonary hypertension, unrepaired aortic dissection, left main stenosis of 50 percent or greater, marked aortic stenosis, chronic or dissecting aortic aneurysm, recent pulmonary embolism, hypertrophic cardiomyopathy, limiting neurological or musculoskeletal impairments, or an acute illness. In addition, an exercise test should not be purchased for individuals for whom the performance of the test is considered to constitute a significant risk by a program physician, preferably one experienced in the care of patients with cardiovascular disease, even in the absence of any of the above risk factors. In defining risk, the program physician, in accordance with the regulations and other instructions on consultative examinations, will generally give great weight to the treating physicians' opinions and will generally not override them. In the rare situation in which the program physician does override the treating source's opinion, a written rationale must be prepared documenting the reasons for overriding the opinion.

d. In order to permit maximal, attainable restoration of functional capacity, exercise testing should not be purchased until 3 months after an acute myocardial infarction, surgical myocardial revascularization, or other open-heart surgical procedures. Purchase of an exercise test should also be deferred for 3 months after percutaneous transluminal coronary angioplasty because restenosis with ischemic symptoms may occur within a few months of angioplasty (see 4.00D). Also, individuals who have had a period of bedrest or inactivity (e.g., 2 weeks) that results in a reversible deconditioned state may do poorly if exercise testing is performed at that time.

e. Evaluation.

(1) Exercise testing is evaluated on the basis of the work level at which the test becomes abnormal, as documented by onset of signs or symptoms and any ECG abnormalities listed in 4.04A. The ability or inability to complete an exercise test is not, by itself, evidence that a person is free from ischemic heart disease. The results of an exercise test must be considered in the context of all of the other evidence in the individual's case record. If the individual is under the care of a treating physician for a cardiac impairment, and this physician has not performed an exercise test and there are no reported significant risks to testing (see 4.00C2c), a statement should be requested from the treating physician explaining why it was not done or should not be done before deciding

whether an exercise test should be purchased. In those rare situations in which the treating source's opinion is overridden, follow 4.00C2c. If there is no treating physician, the program physician will be responsible for assessing the risk to exercise testing.

(2) Limitations to exercise test interpretation include the presence of noncoronary or nonischemic factors that may influence the hemodynamic and ECG response to exercise, such as hypokalemia or other electrolyte abnormality, hyperventilation, vasoregulatory deconditioning, prolonged periods of physical inactivity (e.g., 2 weeks of bedrest), significant anemia, left bundle branch block pattern on the ECG (and other conduction abnormalities that do not preclude the purchase of exercise testing), and other heart diseases or abnormalities (particularly valvular heart disease). Digitalis glycosides may cause ST segment abnormalities at rest, during, and after exercise. Digitalis or other drug-related ST segment displacement with exercise and make ECG interpretation difficult, but such drugs do not invalidate an otherwise normal exercise test. Diuretic-induced hypokalemia and left ventricular hypertrophy may also be associated with repolarization changes and behave similarly. Finally, treatment with beta blockers slows the heart rate more at near-maximal exertion than at rest; this limits apparent chronotropic capacity.

3. Other Studies

Information from two-dimensional and Doppler echocardiographic studies of ventricular size and function as well as radionuclide (thallium²⁰¹) myocardial "perfusion" or radionuclide (technetium 99m) ventriculograms (RVG or MUGA) may be useful. These techniques can provide a reliable estimate of ejection fraction. In selected cases, these tests may be purchased after a medical history and physical examination, report of chest x-rays, ECGs, and other appropriate tests have been evaluated, preferably by a program physician with experience in the care of patients with cardiovascular disease. Purchase should be considered when other information available is not adequate to assess whether the individual may have severe ventricular dysfunction or myocardial ischemia and there is no significant risk involved (follow 4.00C2a guides), and the claim cannot be favorably decided on any other basis.

Exercise testing with measurement of maximal oxygen uptake (VO_2) provides an accurate determination of aerobic capacity. An exercise test without measurement of oxygen uptake provides an estimate of aerobic capacity. When the results of tests with measurement of oxygen uptake are avail-

able, every reasonable effort should be made to obtain them.

The recording of properly calibrated ambulatory ECGs for analysis of ST segment signals with a concomitantly recorded symptom and treatment log may permit more adequate evaluation of chest discomfort during activities of daily living, but the significance of these data for disability evaluation has not been established in the absence of symptoms (e.g., silent ischemia). This information (including selected segments of both the ECG recording and summary report of the patient diary) may be submitted for the record.

4. Cardiac catheterization will not be purchased by the Social Security Administration.

a. Coronary arteriography. If results of such testing are available, the report should be obtained and considered as to the quality and type of data provided and its relevance to the evaluation of the impairment. A copy of the report of the cardiac catheterization and ancillary studies should also be obtained. The report should provide information citing the method of assessing coronary arterial lumen diameter and the nature and location of obstructive lesions. Drug treatment at baseline and during the procedure should be reported. Coronary artery spasm induced by intracoronary catheterization is not to be considered evidence of ischemic disease. Some individuals with significant coronary atherosclerotic obstruction have collateral vessels that supply the myocardium distal to the arterial obstruction so that there is no evidence of myocardial damage or ischemia, even with exercise. When available, quantitative computer measurements and analyses should be considered in the interpretation of severity of stenotic lesions.

b. Left ventriculography (by angiography). The report should describe the wall motion of the myocardium with regard to any areas of hypokinesis, akinesis, or dyskinesis, and the overall contraction of the ventricle as measured by the ejection fraction. Measurement of chamber volumes and pressures may be useful. When available, quantitative computer analysis provides precise measurement of segmental left ventricular wall thickness and motion. There is often a poor correlation between left ventricular function at rest and functional capacity for physical activity.

D. Treatment and relationship to functional status.

1. In general, conclusions about the severity of a cardiovascular impairment cannot be made on the basis of type of treatment rendered or anticipated. The overall clinical and laboratory evidence, including the treatment plan(s) or results, should be persuasive that a listing-level impairment exists. The amount of function restored and the time required for improvement after treatment

(medical, surgical, or a prescribed program of progressive physical activity) vary with the nature and extent of the disorder, the type of treatment, and other factors. Depending upon the timing of this treatment in relation to the alleged onset date of disability, impairment evaluation may need to be deferred for a period of up to 3 months from the date of treatment to permit consideration of treatment effects. Evaluation should not be deferred if the claim can be favorably decided based upon the available evidence.

2. The usual time after myocardial infarction, valvular and/or revascularization surgery for adequate assessment of the results of treatment is considered to be 3 months. If an exercise test is performed by a treating source within a week or two after angioplasty, and there is no significant change in clinical status during the 3-month period after the angioplasty that would invalidate the implications of the exercise test results, the exercise test results may be used to reflect functional capacity during the period in question. However, if the test was done immediately following an acute myocardial infarction or during a period of protracted inactivity, the results should not be projected to 3 months even if there is no change in clinical status.

3. An individual who has undergone cardiac transplantation will be considered under a disability for 1 year following the surgery because, during the first year, there is a greater likelihood of rejection of the organ and recurrent infection. After the first year posttransplantation, continuing disability evaluation will be based upon residual impairment as shown by symptoms, signs, and laboratory findings. Absence of symptoms, signs, and laboratory findings indicative of cardiac dysfunction will be included in the consideration of whether medical improvement (as defined in §§ 404.1579(b)(1) and (c)(1), 404.1594(b)(1) and (c)(1), or 416.994(b)(1)(i) and (b)(2)(i), as appropriate) has occurred.

E. Clinical syndromes.

1. Chronic heart failure (ventricular dysfunction) is considered in these listings as one category whatever its etiology, i.e., atherosclerotic, hypertensive, rheumatic, pulmonary, congenital or other organic heart disease. Chronic heart failure may manifest itself by:

- a. Pulmonary or systemic congestion, or both; or
- b. Symptoms of limited cardiac output, such as weakness, fatigue, or intolerance of physical activity.

For the purpose of 4.02A, pulmonary and systemic congestion are not considered to have been established unless there is or has been evidence of fluid retention, such as hepatomegaly or ascites, or peripheral or pulmonary edema of cardiac origin. The findings of fluid retention need not be present at the time of adjudication because congestion

may be controlled with medication. Chronic heart failure due to limited cardiac output is not considered to have been established for the purpose of 4.02B unless symptoms occur with ordinary daily activities, i.e., activity restriction as manifested by a need to decrease activity or pace, or to rest intermittently, and are associated with one or more physical signs or abnormal laboratory studies listed in 4.02B. These studies include exercise testing with ECG and blood pressure recording and/or appropriate imaging techniques, such as two-dimensional echocardiography or radionuclide or contrast ventriculography. The exercise criteria are outlined in 4.02B1. In addition, other abnormal symptoms, signs, or laboratory test results that lend credence to the impression of ventricular dysfunction should be considered.

2. For the purposes of 4.03, hypertensive cardiovascular disease is evaluated by reference to the specific organ system involved (heart, brain, kidneys, or eyes). The presence of organic impairment must be established by appropriate physical signs and laboratory test abnormalities as specified in 4.02 or 4.04, or for the body system involved.

3. Ischemic (coronary) heart disease may result in an impairment due to myocardial ischemia and/or ventricular dysfunction or infarction. For the purposes of 4.04, the clinical determination that discomfort of myocardial ischemic origin (angina pectoris) is present must be supported by objective evidence as described under 4.00C1, 2, 3, or 4.

a. Discomfort of myocardial ischemic origin (angina pectoris) is discomfort that is precipitated by effort and/or emotion and promptly relieved by sublingual nitroglycerin, other rapidly acting nitrates, or rest. Typically the discomfort is located in the chest (usually substernal) and described as crushing, squeezing, burning, aching, or oppressive. Sharp, sticking, or cramping discomfort is considered less common or atypical. Discomfort occurring with activity or emotion should be described specifically as to timing and usual inciting factors (type and intensity), character, location, radiation, duration, and response to nitrate therapy or rest.

b. So-called anginal equivalent may be localized to the neck, jaw(s), or hand(s) and has the same precipitating and relieving factors as typical chest discomfort. Isolated shortness of breath (dyspnea) is not considered an anginal equivalent for purposes of adjudication.

c. Variant angina of the Prinzmetal type, i.e., rest angina with transitory ST segment elevation on ECG, may have the same significance as typical angina, described in 4.00E3a.

d. If there is documented evidence of silent ischemia or restricted activity to prevent chest discomfort, this information must be

considered along with all available evidence to determine if an equivalence decision is appropriate.

e. Chest discomfort of myocardial ischemic origin is usually caused by coronary artery disease. However, ischemic discomfort may be caused by noncoronary artery conditions, such as critical aortic stenosis, hypertrophic cardiomyopathy, pulmonary hypertension, or anemia. These conditions should be distinguished from coronary artery disease, because the evaluation criteria, management, and prognosis (duration) may differ from that of coronary artery disease.

f. Chest discomfort of nonischemic origin may result from other cardiac conditions such as pericarditis and mitral valve prolapse. Noncardiac conditions may also produce symptoms mimicking that of myocardial ischemia. These conditions include gastrointestinal tract disorders, such as esophageal spasm, esophagitis, hiatal hernia, biliary tract disease, gastritis, peptic ulcer, and pancreatitis, and musculoskeletal syndromes, such as chest wall muscle spasm, chest wall syndrome (especially after coronary bypass surgery), costochondritis, and cervical or dorsal arthritis. Hyperventilation may also mimic ischemic discomfort. Such disorders should be considered before concluding that chest discomfort is of myocardial ischemic origin.

4. Peripheral Arterial Disease

The level of impairment is based on the symptomatology, physical findings, Doppler studies before and after a standard exercise test, or angiographic findings.

The requirements for evaluating peripheral arterial disease in 4.12B are based on the ratio of the systolic blood pressure at the ankle to the systolic blood pressure at the brachial artery, determined in the supine position at the same time. Techniques for obtaining ankle systolic blood pressures include Doppler, plethysmographic studies, or other techniques.

Listing 4.12B1 is met when the resting ankle/brachial systolic blood pressure ratio is less than 0.50. Listing 4.12B2 provides additional criteria for evaluating peripheral arterial impairment on the basis of exercise studies when the resting ankle/brachial systolic blood pressure ratio is 0.50 or above. The decision to obtain exercise studies should be based on an evaluation of the existing clinical evidence, but exercise studies are rarely warranted when the resting ankle-over-brachial systolic blood pressure ratio is 0.80 or above. The results of exercise studies should describe the level of exercise, e.g., speed and grade of the treadmill settings, the duration of exercise, symptoms during exercise, the reasons for stopping exercise if the expected level of exercise was not attained, blood pressures at the ankle and other pertinent sites measured after exercise, and the

time required to return the systolic blood pressure toward or to the pre-exercise level. When an exercise Doppler study is purchased by the Social Security Administration, the requested exercise must be on a treadmill at 2 mph on a 10 or 12 percent grade for 5 minutes. Exercise studies should not be performed on individuals for whom exercise poses a significant risk.

Application of the criteria in 4.12B may be limited in individuals who have marked calcific (Monckeberg's) sclerosis of the peripheral arteries or marked small vessel disease associated with diabetes mellitus.

4.01 Category of Impairments, Cardiovascular System

4.02 Chronic heart failure while on a regimen of prescribed treatment (see 4.00A if there is no regimen of prescribed treatment). With one of the following:

A. Documented cardiac enlargement by appropriate imaging techniques (e.g., a cardiothoracic ratio of greater than 0.50 on a PA chest x-ray with good inspiratory effort or left ventricular diastolic diameter of greater than 5.5 cm on two-dimensional echocardiography), resulting in inability to carry on any physical activity, and with symptoms of inadequate cardiac output, pulmonary congestion, systemic congestion, or anginal syndrome at rest (e.g., recurrent or persistent fatigue, dyspnea, orthopnea, anginal discomfort);

OR

B. Documented cardiac enlargement by appropriate imaging techniques (see 4.02A) or ventricular dysfunction manifested by S3, abnormal wall motion, or left ventricular ejection fraction of 30 percent or less by appropriate imaging techniques; and

1. Inability to perform on an exercise test at a workload equivalent to 5 METs or less due to symptoms of chronic heart failure, or, in rare instances, a need to stop exercise testing at less than this level of work because of:

a. Three or more consecutive ventricular premature beats or three or more multiform beats; or

b. Failure to increase systolic blood pressure by 10 mmHg, or decrease in systolic pressure below the usual resting level (see 4.00C2b); or

c. Signs attributable to inadequate cerebral perfusion, such as ataxic gait or mental confusion; and

2. Resulting in marked limitation of physical activity, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though the individual is comfortable at rest;

OR

C. Cor pulmonale fulfilling the criteria in 4.02A or B.

4.03 *Hypertensive cardiovascular disease.* Evaluate under 4.02 or 4.04, or under the criteria for the affected body system (2.02 through 2.04, 6.02, or 11.04A or B).

4.04 *Ischemic heart disease.* with chest discomfort associated with myocardial ischemia, as described in 4.00E3, while on a regimen of prescribed treatment (see 4.00A if there is no regimen of prescribed treatment). With one of the following:

A. Sign- or symptom-limited exercise test demonstrating at least one of the following manifestations at a workload equivalent to 5 METs or less:

1. Horizontal or downsloping depression, in the absence of digitalis glycoside therapy and/or hypokalemia, of the ST segment of at least -0.10 millivolts (-1.0 mm) in at least 3 consecutive complexes that are on a level baseline in any lead (other than aVR) and that have a typical ischemic time course of development and resolution (progression of horizontal or downsloping ST depression with exercise, and persistence of depression of at least -0.10 millivolts for at least 1 minute of recovery); or

2. An upslowing ST junction depression, in the absence of digitalis glycoside therapy and/or hypokalemia, in any lead (except aVR) of at least -0.2 millivolts or more for at least 0.08 seconds after the J junction and persisting for at least 1 minute of recovery; or

3. At least 0.1 millivolt (1 mm) ST elevation above resting baseline during both exercise and 3 or more minutes of recovery in ECG leads with low R and T waves in the leads demonstrating the ST segment displacement; or

4. Failure to increase systolic pressure by 10 mmHg, or decrease in systolic pressure below usual clinical resting level (see 4.00C2b); or

5. Documented reversible radionuclide "perfusion" (thallium²⁰¹) defect at an exercise level equivalent to 5 METs or less;

OR

B. Impaired myocardial function, documented by evidence (as outlined under 4.00C3 or 4.00C4b) of hypokinetic, akinetic, or dyskinetic myocardial free wall or septal wall motion with left ventricular ejection fraction of 30 percent or less, and an evaluating program physician, preferably one experienced in the care of patients with cardiovascular disease, has concluded that performance of exercise testing would present a significant risk to the individual, and resulting in marked limitation of physical activity, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though the individual is comfortable at rest;

OR

C. Coronary artery disease, demonstrated by angiography (obtained independent of Social Security disability evaluation), and an

evaluating program physician, preferably one experienced in the care of patients with cardiovascular disease, has concluded that performance of exercise testing would present a significant risk to the individual, with both 1 and 2:

1. Angiographic evidence revealing:

a. 50 percent or more narrowing of a non-bypassed left main coronary artery; or

b. 70 percent or more narrowing of another nonbypassed coronary artery; or

c. 50 percent or more narrowing involving a long (greater than 1 cm) segment of a non-bypassed coronary artery; or

d. 50 percent or more narrowing of at least 2 nonbypassed coronary arteries; or

e. Total obstruction of a bypass graft vessel; and

2. Resulting in marked limitation of physical activity, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though the individual is comfortable at rest.

4.05 *Recurrent arrhythmias*, not related to reversible causes such as electrolyte abnormalities or digitalis glycoside or antiarrhythmic drug toxicity, resulting in uncontrolled repeated episodes of cardiac syncope or near syncope and arrhythmia despite prescribed treatment (see 4.00A if there is no prescribed treatment), documented by resting or ambulatory (Holter) electrocardiography coincident with the occurrence of syncope or near syncope.

4.06 *Symptomatic congenital heart disease* (cyanotic or acyanotic), documented by appropriate imaging techniques (as outlined under 4.00C3) or cardiac catheterization. With one of the following:

A. Cyanosis at rest; and

1. Hematocrit of 55 percent or greater, or

2. Arterial O₂ saturation of less than 90 percent in room air, or resting arterial PO₂ of 60 Torr or less;

OR

B. Intermittent right-to-left shunting resulting in cyanosis on exertion (e.g., Eisenmenger's physiology) and with arterial PO₂ of 60 Torr or less at a workload equivalent to 5 METs or less;

OR

C. Chronic heart failure with evidence of ventricular dysfunction, as described in 4.02;

OR

D. Recurrent arrhythmias as described in 4.05;

OR

E. Secondary pulmonary vascular obstructive disease with a mean pulmonary arterial pressure elevated to at least 70 percent of the mean systemic arterial pressure.

4.07 *Valvular heart disease or other stenotic defects*, or valvular regurgitation, documented by appropriate imaging techniques or cardiac catheterization. Evaluate under the criteria in 4.02, 4.04, 4.05, or 11.04.

4.08 *Cardiomyopathies*, documented by appropriate imaging techniques or cardiac catheterization. Evaluate under the criteria in 4.02, 4.04, 4.05, or 11.04.

4.09 *Cardiac transplantation.* Consider under a disability for 1 year following surgery; thereafter, reevaluate residual impairment under 4.02 to 4.08.

4.10 *Aneurysm of aorta or major branches*, due to any cause (e.g., atherosclerosis, cystic medial necrosis, Marfan syndrome, trauma), demonstrated by an appropriate imaging technique. With one of the following:

A. Acute or chronic dissection not controlled by prescribed medical or surgical treatment;

OR

B. Chronic heart failure as described under 4.02;

OR

C. Renal failure as described under 6.02;

OR

D. Neurological complications as described under 11.04.

4.11 *Chronic venous insufficiency* of a lower extremity. With incompetency or obstruction of the deep venous system and one of the following:

A. Extensive brawny edema;

OR

B. Superficial varicosities, stasis dermatitis, and recurrent or persistent ulceration which has not healed following at least 3 months of prescribed medical or surgical therapy.

4.12 *Peripheral arterial disease.* With one of the following:

A. Intermittent claudication with failure to visualize (on arteriogram obtained independent of Social Security disability evaluation) the common femoral or deep femoral artery in one extremity;

OR

B. Intermittent claudication with marked impairment of peripheral arterial circulation as determined by Doppler studies showing:

1. Resting ankle/brachial systolic blood pressure ratio of less than 0.50; or

2. Decrease in systolic blood pressure at the ankle on exercise (see 4.00E4) of 50 percent or more of pre-exercise level at the ankle, and requiring 10 minutes or more to return to pre-exercise level;

OR

C. Amputation at or above the tarsal region due to peripheral vascular disease.

5.00 DIGESTIVE SYSTEM

A. *Disorders of the digestive system* which result in a marked impairment usually do so because of interference with nutrition, multiple recurrent inflammatory lesions, or complications of disease, such as fistulae, abscesses, or recurrent obstruction. Such complications usually respond to treatment. These complications must be shown to persist on repeated examinations despite therapy

for a reasonable presumption to be made that a marked impairment will last for a continuous period of at least 12 months.

B. *Malnutrition or weight loss from gastrointestinal disorders.* When the primary disorder of the digestive tract has been established (e.g. enterocolitis, chronic pancreatitis, postgastrointestinal resection, or esophageal stricture, stenosis, or obstruction), the resultant interference with nutrition will be considered under the criteria in 5.08. This will apply whether the weight loss is due to primary or secondary disorders of malabsorption, malassimilation or obstruction. However, weight loss not due to diseases of the digestive tract, but associated with psychiatric or primary endocrine or other disorders, should be evaluated under the appropriate criteria for the underlying disorder.

C. *Surgical diversion of the intestinal tract*, including colostomy or ileostomy, are not listed since they do not represent impairments which preclude all work activity if the individual is able to maintain adequate nutrition and function of the stoma. Dumping syndrome which may follow gastric resection rarely represents a marked impairment which would continue for 12 months. Peptic ulcer disease with recurrent ulceration after definitive surgery ordinarily responds to treatment. A recurrent ulcer after definitive surgery must be demonstrated on repeated upper gastrointestinal roentgenograms or gastroscopic examinations despite therapy to be considered a severe impairment which will last for at least 12 months. Definitive surgical procedures are those designed to control the ulcer disease process (i.e., vagotomy and pyloroplasty, subtotal gastrectomy, etc.). Simple closure of a perforated ulcer does not constitute definitive surgical therapy for peptic ulcer disease.

5.01 *Category of Impairments, Digestive System*

5.02 *Recurrent upper gastrointestinal hemorrhage from undetermined cause with anemia* manifested by hematocrit of 30 percent or less on repeated examinations.

5.03 *Stricture, stenosis, or obstruction of the esophagus (demonstrated by X-ray or endoscopy)* with weight loss as described under §5.08.

5.04 *Peptic ulcer disease (demonstrated by X-ray or endoscopy).* With:

A. Recurrent ulceration after definitive surgery persistent despite therapy; or

B. Inoperable fistula formation; or

C. Recurrent obstruction demonstrated by X-ray or endoscopy. or

D. Weight loss as described under §5.08.

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

A. Esophageal varices (demonstrated by X-ray or endoscopy) with a documented history of massive hemorrhage attributable to these

varices. Consider under a disability for 3 years following the last massive hemorrhage; thereafter, evaluate the residual impairment; or

B. Performance of a shunt operation for esophageal varices. Consider under a disability for 3 years following surgery; thereafter, evaluate the residual impairment; or

C. Serum bilirubin of 2.5 mg. per deciliter (100 ml.) or greater persisting on repeated examinations for at least 5 months; or

D. Ascites, not attributable to other causes, recurrent or persisting for at least 5 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm. per deciliter (100 ml.) or less; or

E. Hepatic encephalopathy. Evaluate under the criteria in listing 12.02; or

F. Confirmation of chronic liver disease by liver biopsy (obtained independent of Social Security disability evaluation) and one of the following:

1. Ascites not attributable to other causes, recurrent or persisting for at least 3 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm. per deciliter (100 ml.) or less; or

2. Serum bilirubin of 2.5 mg. per deciliter (100 ml.) or greater on repeated examinations for at least 3 months; or

3. Hepatic cell necrosis or inflammation, persisting for at least 3 months, documented by repeated abnormalities of prothrombin time and enzymes indicative of hepatic dysfunction.

5.06 *Chronic ulcerative or granulomatous colitis (demonstrated by endoscopy, barium enema, biopsy, or operative findings).* With:

A. Recurrent bloody stools documented on repeated examinations and anemia manifested by hematocrit of 30 percent or less on repeated examinations; or

B. Persistent or recurrent systemic manifestations, such as arthritis, iritis, fever, or liver dysfunction, not attributable to other causes; or

C. Intermittent obstruction due to intractable abscess, fistula formation, or stenosis; or

D. Recurrence of findings of A, B, or C above after total colectomy; or

E. Weight loss as described under § 5.08.

5.07 *Regional enteritis (demonstrated by operative findings, barium studies, biopsy, or endoscopy).* With:

A. Persistent or recurrent intestinal obstruction evidenced by abdominal pain, distention, nausea, and vomiting and accompanied by stenotic areas of small bowel with proximal intestinal dilation; or

B. Persistent or recurrent systemic manifestations such as arthritis, iritis, fever, or liver dysfunction, not attributable to other causes; or

C. Intermittent obstruction due to intractable abscess or fistula formation; or

D. Weight loss as described under § 5.08.

5.08 *Weight loss due to any persisting gastrointestinal disorder.* (The following weights are to be demonstrated to have persisted for at least 3 months despite prescribed therapy and expected to persist at this level for at least 12 months.) With:

A. Weight equal to or less than the values specified in Table I or II; or

B. Weight equal to or less than the values specified in Table III or IV and one of the following abnormal findings on repeated examinations:

1. Serum albumin of 3.0 gm. per deciliter (100 ml.) or less; or

2. Hematocrit of 30 percent or less; or

3. Serum calcium of 8.0 mg. per deciliter (100 ml.) (4.0 mEq./L.) or less; or

4. Uncontrolled diabetes mellitus due to pancreatic dysfunction with repeated hyperglycemia, hypoglycemia, or ketosis; or

5. Fat in stool of 7 gm. or greater per 24-hour stool specimen; or

6. Nitrogen in stool of 3 gm. or greater per 24-hour specimen; or

7. Persistent or recurrent ascites or edema not attributable to other causes.

Tables of weight reflecting malnutrition scaled according to height and sex—To be used only in connection with 5.08.

TABLE I—MEN

Height (inches) ¹	Weight (pounds)
61	90
62	92
63	94
64	97
65	99
66	102
67	106
68	109
69	112
70	115
71	118
72	122
73	125
74	128
75	131
76	134

¹ Height measured without shoes.

TABLE II—WOMEN

Height (inches) ¹	Weight (pounds)
58	77
59	79
60	82
61	84
62	86
63	89
64	91
65	94
66	96
67	101
68	104
69	107

Social Security Administration

TABLE II—WOMEN—Continued

Height (inches) ¹	Weight (pounds)
70	110
71	114
72	117
73	120

¹ Height measured without shoes.

TABLE III—MEN

Height (inches) ¹	Weight (pounds)
61	95
62	98
63	100
64	103
65	106
66	109
67	112
68	116
69	119
70	122
71	126
72	129
73	133
74	136
75	139
76	143

¹ Height measured without shoes.

TABLE IV—WOMEN

Height (inches) ¹	Weight (pounds)
58	82
59	84
60	87
61	89
62	92
63	94
64	97
65	100
66	104
67	107
68	111
69	114
70	117
71	121
72	124
73	128

¹ Height measured without shoes.

6.00 GENITO-URINARY SYSTEM

A. *Determination of the presence of chronic renal disease will be based upon* (1) a history, physical examination, and laboratory evidence of renal disease, and (2) indications of its progressive nature or laboratory evidence of deterioration of renal function.

B. *Nephrotic Syndrome.* The medical evidence establishing the clinical diagnosis must include the description of extent of tissue edema, including pretibial, periorbital, or presacral edema. The presence of ascites, pleural effusion, pericardial effusion, and hydroarthrosis should be described if present. Results of pertinent laboratory

tests must be provided. If a renal biopsy has been performed, the evidence should include a copy of the report of microscopic examination of the specimen. Complications such as severe orthostatic hypotension, recurrent infections or venous thromboses should be evaluated on the basis of resultant impairment.

C. *Hemodialysis, peritoneal dialysis, and kidney transplantation.* When an individual is undergoing periodic dialysis because of chronic renal disease, severity of impairment is reflected by the renal function prior to the institution of dialysis.

The amount of function restored and the time required to effect improvement in an individual treated by renal transplant depend upon various factors, including adequacy of post transplant renal function, incidence and severity of renal infection, occurrence of rejection crisis, the presence of systemic complications (anemia, neuropathy, etc.) and side effects of corticosteroids or immuno-suppressive agents. A convalescent period of at least 12 months is required before it can be reasonably determined whether the individual has reached a point of stable medical improvement.

D. *Evaluate associated disorders and complications* according to the appropriate body system listing.

6.01 Category of Impairments, Genito-Urinary System

6.02 Impairment of renal function, due to any chronic renal disease expected to last 12 months (e.g., hypertensive vascular disease, chronic nephritis, nephrolithiasis, polycystic disease, bilateral hydronephrosis, etc.) With:

A. Chronic hemodialysis or peritoneal dialysis necessitated by irreversible renal failure; or

B. Kidney transplant. Consider under a disability for 12 months following surgery; thereafter, evaluate the residual impairment (see 6.00C); or

C. Persistent elevation of serum creatine in to 4 mg. per deciliter (100 ml.) or greater or reduction of creatinine clearance to 20 ml. per minute (29 liters/24 hours) or less, over at least 3 months, with one of the following:

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

2. A clinical episode of pericarditis; or

3. Persistent motor or sensory neuropathy; or

4. Intractable pruritus; or

5. Persistent fluid overload syndrome resulting in diastolic hypertension (110 mm. or above) or signs of vascular congestion; or

6. Persistent anorexia with recent weight loss and current weight meeting the values in 5.08, Table III or IV; or

7. Persistent hematocrits of 30 percent or less.

6.06 *Nephrotic syndrome, with significant anasarca, persistent for at least 3 months despite prescribed therapy.* With:

A. Serum albumin of 3.0 gm. per deciliter (100 ml.) or less and proteinuria of 3.5 gm. per 24 hours or greater; or

B. Proteinuria of 10.0 gm. per 24 hours or greater.

7.00 HEMIC AND LYMPHATIC SYSTEM

A. *Impairment caused by anemia* should be evaluated according to the ability of the individual to adjust to the reduced oxygen carrying capacity of the blood. A gradual reduction in red cell mass, even to very low values, is often well tolerated in individuals with a healthy cardiovascular system.

B. *Chronicity is indicated* by persistence of the condition for at least 3 months. The laboratory findings cited must reflect the values reported on more than one examination over that 3-month period.

C. *Sickle cell disease* refers to a chronic hemolytic anemia associated with sickle cell hemoglobin, either homozygous or in combination with thalassemia or with another abnormal hemoglobin (such as C or F).

Appropriate hematologic evidence for sickle cell disease, such as hemoglobin electrophoresis, must be included. Vasoocclusive or aplastic episodes should be documented by description of severity, frequency, and duration.

Major visceral episodes include meningitis, osteomyelitis, pulmonary infections or infarctions, cerebrovascular accidents, congestive heart failure, genito-urinary involvement, etc.

D. *Coagulation defects.* Chronic inherited coagulation disorders must be documented by appropriate laboratory evidence. Prophylactic therapy such as with antihemophilic globulin (AHG) concentrate does not in itself imply severity.

E. *Acute leukemia.* Initial diagnosis of acute leukemia must be based upon definitive bone marrow pathologic evidence. Recurrent disease may be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. The pathology report must be included.

The acute phase of chronic myelocytic (granulocytic) leukemia should be considered under the requirements for acute leukemia.

The criteria in 7.11 contain the designated duration of disability implicit in the finding of a listed impairment. Following the designated time period, a documented diagnosis itself is no longer sufficient to establish a marked impairment. The level of any remaining impairment must be evaluated on the basis of the medical evidence.

7.01 *Category of Impairments, Hemic and Lymphatic System*

7.02 *Chronic anemia (hematocrit persisting at 30 percent or less due to any cause).* With:

A. Requirement of one or more blood transfusions on an average of at least once every 2 months; or

B. Evaluation of the resulting impairment under criteria for the affected body system.

7.05 *Sickle cell disease, or one of its variants.* With:

A. Documented painful (thrombotic) crises occurring at least three times during the 5 months prior to adjudication; or

B. Requiring extended hospitalization (beyond emergency care) at least three times during the 12 months prior to adjudication; or

C. Chronic, severe anemia with persistence of hematocrit of 26 percent or less; or

D. Evaluate the resulting impairment under the criteria for the affected body system.

7.06 *Chronic thrombocytopenia (due to any cause)* with platelet counts repeatedly below 40,000/cubic millimeter. With:

A. At least one spontaneous hemorrhage, requiring transfusion, within 5 months prior to adjudication; or

B. Intracranial bleeding within 12 months prior to adjudication.

7.07 *Hereditary telangiectasia* with hemorrhage requiring transfusion at least three times during the 5 months prior to adjudication.

7.08 *Coagulation defects (hemophilia or a similar disorder)* with spontaneous hemorrhage requiring transfusion at least three times during the 5 months prior to adjudication.

7.09 *Polycythemia vera (with erythrocytosis, splenomegaly, and leukocytosis or thrombocytosis).* Evaluate the resulting impairment under the criteria for the affected body system.

7.10 *Myelofibrosis (myeloproliferative syndrome).* With:

A. Chronic anemia. Evaluate according to the criteria of § 7.02; or

B. Documented recurrent systemic bacterial infections occurring at least 3 times during the 5 months prior to adjudication; or

C. Intractable bone pain with radiologic evidence of osteosclerosis.

7.11 *Acute leukemia.* Consider under a disability for 2½ years from the time of initial diagnosis.

7.12 *Chronic leukemia.* Evaluate according to the criteria of 7.02, 7.06, 7.10B, 7.11, 7.17, or 13.06A.

7.13 *Lymphomas.* Evaluate under the criteria in 13.06A.

7.14 *Macroglobulinemia or heavy chain disease,* confirmed by serum or urine protein electrophoresis or immunoelectrophoresis. Evaluate impairment under criteria for affected body system or under 7.02, 7.06, or 7.08.

7.15 *Chronic granulocytopenia (due to any cause).* With both A and B:

A. Absolute neutrophil counts repeatedly below 1,000 cells/cubic millimeter; and

Social Security Administration

B. Documented recurrent systemic bacterial infections occurring at least 3 times during the 5 months prior to adjudication.

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

A. Radiologic evidence of bony involvement with intractable bone pain; or

B. Evidence of renal impairment as described in 6.02; or

C. Hypercalcemia with serum calcium levels persistently greater than 11 mg. per deciliter (100 ml.) for at least 1 month despite prescribed therapy; or

D. Plasma cells (100 or more cells/cubic millimeter) in the peripheral blood.

7.17 *Aplastic anemias or hematologic malignancies (excluding acute leukemia):* With bone marrow transplantation. Consider under a disability for 12 months following transplantation; thereafter, evaluate according to the primary characteristics of the residual impairment.

8.00 SKIN

A. *Skin lesions* may result in a marked, long-lasting impairment if they involve extensive body areas or critical areas such as the hands or feet and become resistant to treatment. These lesions must be shown to have persisted for a sufficient period of time despite therapy for a reasonable presumption to be made that a marked impairment will last for a continuous period of at least 12 months. The treatment for some of the skin diseases listed in this section may require the use of high dosage of drugs with possible serious side effects; these side effects should be considered in the overall evaluation of impairment.

B. *When skin lesions are associated with systemic disease* and where that is the predominant problem, evaluation should occur according to the criteria in the appropriate section. Disseminated (systemic) lupus erythematosus and scleroderma usually involve more than one body system and should be evaluated under 14.02 and 14.04. Neoplastic skin lesions should be evaluated under 13.00ff. When skin lesions (including burns) are associated with contractures or limitation of joint motion, that impairment should be evaluated under 1.00ff.

8.01 *Category of Impairments, Skin*

8.02 *Exfoliative dermatitis, ichthyosis, ichthyosiform erythroderma.* With extensive lesions not responding to prescribed treatment.

8.03 *Pemphigus, erythema multiforme bullosum, bullous pemphigoid, dermatitis herpetiformis.* With extensive lesions not responding to prescribed treatment.

8.04 *Deep mycotic infections.* With extensive fungating, ulcerating lesions not responding to prescribed treatment.

8.05 *Psoriasis, atopic dermatitis, dyshidrosis.* With extensive lesions, including involve-

ment of the hands or feet which impose a marked limitation of function and which are not responding to prescribed treatment.

8.06 *Hydradenitis suppurative, acne conglobata.* With extensive lesions involving the axillae or perineum not responding to prescribed medical treatment and not amenable to surgical treatment.

9.00 ENDOCRINE SYSTEM AND OBESITY

Cause of impairment. Impairment is caused by overproduction or underproduction of hormones, resulting in structural or functional changes in the body. Where involvement of other organ systems has occurred as a result of a primary endocrine disorder, these impairments should be evaluated according to the criteria under the appropriate sections.

Long-term massive obesity will usually be associated with disorders of the musculoskeletal, cardiovascular, peripheral vascular, and pulmonary systems, and the occurrence of these disorders is the major cause of disability at the listing level. Extreme obesity results in restrictions imposed by body weight and the additional restrictions imposed by disturbances in other body systems. The weight-bearing criterion in 9.09A refers to the lumbosacral spine. The cervical and thoracic spines are not considered weight-bearing.

9.01 *Category of Impairments, Endocrine System and Obesity*

9.02 *Thyroid Disorders.* With:

A. Progressive exophthalmos as measured by exophthalmometry; or

B. Evaluate the resulting impairment under the criteria for the affected body system.

9.03 *Hyperparathyroidism.* With:

A. Generalized decalcification of bone on X-ray study and elevation of plasma calcium to 11 mg. per deciliter (100 ml.) or greater; or

B. A resulting impairment. Evaluate according to the criteria in the affected body system.

9.04 *Hypoparathyroidism.* With:

A. Severe recurrent tetany; or

B. Recurrent generalized convulsions; or

C. Lenticular cataracts. Evaluate under the criteria in 2.00ff.

9.05 *Neurohypophyseal insufficiency (diabetes insipidus).* With urine specific gravity of 1.005 or below, persistent for at least 3 months and recurrent dehydration.

9.06 *Hyperfunction of the adrenal cortex.* Evaluate the resulting impairment under the criteria for the affected body system.

9.08 *Diabetes mellitus.* With:

A. Neuropathy demonstrated by significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C); or

B. Acidosis occurring at least on the average of once every 2 months documented by appropriate blood chemical tests (pH or pCO₂ or bicarbonate levels); or

C. Amputation at, or above, the tarsal region due to diabetic necrosis or peripheral arterial disease; or

D. Retinitis proliferans; evaluate the visual impairment under the criteria in 2.02, 2.03, or 2.04.

9.09 *Obesity*. Weight equal to or greater than the values specified in Table I for males, Table II for females (100 percent above desired level), and one of the following:

A. History of pain and limitation of motion in any weight-bearing joint or the lumbosacral spine (on physical examination) associated with findings on medically acceptable imaging techniques of arthritis in the affected joint or lumbosacral spine; or

B. Hypertension with diastolic blood pressure persistently in excess of 100 mm. Hg measured with appropriate size cuff; or

C. History of congestive heart failure manifested by past evidence of vascular congestion such as hepatomegaly, peripheral or pulmonary edema; or

D. Chronic venous insufficiency with superficial varicosities in a lower extremity with pain on weight bearing and persistent edema; or

E. Respiratory disease with total forced vital capacity equal to or less than 2.0 L. or a level of hypoxemia at rest equal to or less than the values specified in Table III-A or III-B or III-C.

TABLE I.—MEN
[Metric]

Height without shoes (centimeters)	Weight (kilograms)
152	112
155	115
157	117
160	120
163	123
165	125
168	129
170	134
173	137
175	141
178	145
180	149
183	153
185	157
188	162
190	165
193	170

TABLE I.—MEN

Height without shoes (inches)	Weight (pounds)
60	246
61	252
62	258

TABLE I.—MEN—Continued

Height without shoes (inches)	Weight (pounds)
63	264
64	270
65	276
66	284
67	294
68	302
69	310
70	318
71	328
72	336
73	346
74	356
75	364
76	374

TABLE II.—WOMEN
[Metric]

Height without shoes (centimeters)	Weight (kilograms)
142	95
145	98
147	99
150	102
152	105
155	107
157	110
160	114
163	117
165	121
168	125
170	128
173	132
175	135
178	139
180	143
183	148

TABLE II.—WOMEN

Height without shoes (inches)	Weight (pounds)
56	208
57	212
58	218
59	224
60	230
61	236
62	242
63	250
64	258
65	266
66	274
67	282
68	290
69	298
70	306
71	314
72	322

TABLE III—A

[Applicable at test sites less than 3,000 feet above sea level]

Arterial PCO ₂ (mm. Hg) and	Arterial PO ₂ equal to or less than (mm. Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

TABLE III—B

[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO ₂ (mm. Hg) and	Arterial PO ₂ equal to or less than (mm. Hg)
30 or below	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40 or above	50

TABLE III—C

[Applicable at test sites over 6,000 feet above sea level]

Arterial PCO ₂ (mm. Hg) and	Arterial PO ₂ equal to or less than (mm. Hg)
30 or below	55
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

10.00 [RESERVED]

11.00 NEUROLOGICAL

A. *Convulsive disorders*. In convulsive disorders, regardless of etiology degree of impairment will be determined according to type, frequency, duration, and sequelae of

seizures. At least one detailed description of a typical seizure is required. Such description includes the presence or absence of aura, tongue bites, sphincter control, injuries associated with the attack, and postictal phenomena. The reporting physician should indicate the extent to which description of seizures reflects his own observations and the source of ancillary information. Testimony of persons other than the claimant is essential for description of type and frequency of seizures if professional observation is not available.

Documentation of epilepsy should include at least one electroencephalogram (EEG).

Under 11.02 and 11.03, the criteria can be applied only if the impairment persists despite the fact that the individual is following prescribed anticonvulsive treatment. Adherence to prescribed anticonvulsive therapy can ordinarily be determined from objective clinical findings in the report of the physician currently providing treatment for epilepsy. Determination of blood levels of phenytoin sodium or other anticonvulsive drugs may serve to indicate whether the prescribed medication is being taken. When seizures are occurring at the frequency stated in 11.02 or 11.03, evaluation of the severity of the impairment must include consideration of the serum drug levels. Should serum drug levels appear therapeutically inadequate, consideration should be given as to whether this is caused by individual idiosyncrasy in absorption of metabolism of the drug. Blood drug levels should be evaluated in conjunction with all the other evidence to determine the extent of compliance. When the reported blood drug levels are low, therefore, the information obtained from the treating source should include the physician's statement as to why the levels are low and the results of any relevant diagnostic studies concerning the blood levels. Where adequate seizure control is obtained only with unusually large doses, the possibility of impairment resulting from the side effects of this medication must be also assessed. Where documentation shows that use of alcohol or drugs affects adherence to prescribed therapy or may play a part in the precipitation of seizures, this must also be considered in the overall assessment of impairment level.

B. *Brain tumors*. The diagnosis of malignant brain tumors must be established, and the persistence of the tumor should be evaluated, under the criteria described in 13.00B and C for neoplastic disease.

In histologically malignant tumors, the pathological diagnosis alone will be the decisive criterion for severity and expected duration (see 11.05A). For other tumors of the brain, the severity and duration of the impairment will be determined on the basis of symptoms, signs, and pertinent laboratory findings (11.05B).

C. *Persistent disorganization of motor function* in the form of paresis or paralysis, tremor or other involuntary movements, ataxia and sensory disturbances (any or all of which may be due to cerebral cerebellar, brain stem, spinal cord, or peripheral nerve dysfunction) which occur singly or in various combinations, frequently provides the sole or partial basis for decision in cases of neurological impairment. The assessment of impairment depends on the degree of interference with locomotion and/or interference with the use of fingers, hands, and arms.

D. *In conditions which are episodic in character*, such as multiple sclerosis or myasthenia gravis, consideration should be given to frequency and duration of exacerbations, length of remissions, and permanent residuals.

E. *Multiple sclerosis*. The major criteria for evaluating impairment caused by multiple sclerosis are discussed in listing 11.09. Paragraph A provides criteria for evaluating disorganization of motor function and gives reference to 11.04B (11.04B then refers to 11.00C). Paragraph B provides references to other listings for evaluating visual or mental impairments caused by multiple sclerosis. Paragraph C provides criteria for evaluating the impairment of individuals who do not have muscle weakness or other significant disorganization of motor function at rest, but who do develop muscle weakness on activity as a result of fatigue.

Use of the criteria in 11.09C is dependent upon (1) documenting a diagnosis of multiple sclerosis, (2) obtaining a description of fatigue considered to be characteristic of multiple sclerosis, and (3) obtaining evidence that the system has actually become fatigued. The evaluation of the magnitude of the impairment must consider the degree of exercise and the severity of the resulting muscle weakness.

The criteria in 11.09C deals with motor abnormalities which occur on activity. If the disorganization of motor function is present at rest, paragraph A must be used, taking into account any further increase in muscle weakness resulting from activity.

Sensory abnormalities may occur, particularly involving central visual acuity. The decrease in visual acuity may occur after brief attempts at activity involving near vision, such as reading. This decrease in visual acuity may not persist when the specific activity is terminated, as with rest, but is predictably reproduced with resumption of the activity. The impairment of central visual acuity in these cases should be evaluated under the criteria in listing 2.02, taking into account the fact that the decrease in visual acuity will wax and wane.

Clarification of the evidence regarding central nervous system dysfunction responsible for the symptoms may require supporting technical evidence of functional impairment

such as evoked response tests during exercise.

11.01 *Category of Impairments, Neurological*

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

A. Daytime episodes (loss of consciousness and convulsive seizures) or

B. Nocturnal episodes manifesting residuals which interfere significantly with activity during the day.

11.03 *Epilepsy—Minor motor seizures (petit mal, psychomotor, or focal), documented by EEG and by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment. With alteration of awareness or loss of consciousness and transient postictal manifestations of unconventional behavior or significant interference with activity during the day.*

11.04 *Central nervous system vascular accident. With one of the following more than 3 months post-vascular accident:*

A. Sensory or motor aphasia resulting in ineffective speech or communication; or

B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

11.05 *Brain tumors.*

A. Malignant gliomas (astrocytoma—grades III and IV, glioblastoma multiforme), medulloblastoma, ependymoblastoma, or primary sarcoma; or

B. Astrocytoma (grades I and II), meningioma, pituitary tumors, oligodendroglioma, ependymoma, clivus chordoma, and benign tumors. Evaluate under 11.02, 11.03, 11.04 A, or B, or 12.02.

11.06 *Parkinsonian syndrome* with the following signs: Significant rigidity, bradykinesia, or tremor in two extremities, which, singly or in combination, result in sustained disturbance of gross and dexterous movements, or gait and station.

11.07 *Cerebral palsy. With:*

A. IQ of 70 or less; or

B. Abnormal behavior patterns, such as destructiveness or emotional instability; or

C. Significant interference in communication due to speech, hearing, or visual defect; or

D. Disorganization of motor function as described in 11.04B.

11.08 *Spinal cord or nerve root lesions, due to any cause with disorganization of motor function as described in 11.04B.*

11.09 *Multiple sclerosis. With:*

Social Security Administration

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

B. Visual or mental impairment as described under the criteria in 2.02, 2.03, 2.04, or 12.02; or

C. Significant, reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, demonstrated on physical examination, resulting from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process.

11.10 *Amyotrophic lateral sclerosis. With:*

A. Significant bulbar signs; or

B. Disorganization of motor function as described in 11.04B.

11.11 *Anterior poliomyelitis. With:*

A. Persistent difficulty with swallowing or breathing; or

B. Unintelligible speech; or

C. Disorganization of motor function as described in 11.04B.

11.12 *Myasthenia gravis. With:*

A. Significant difficulty with speaking, swallowing, or breathing while on prescribed therapy; or

B. Significant motor weakness of muscles of extremities on repetitive activity against resistance while on prescribed therapy.

11.13 *Muscular dystrophy* with disorganization of motor function as described in 11.04B.

11.14 *Peripheral neuropathies.*

With disorganization of motor function as described in 11.04B, in spite of prescribed treatment.

11.15 *Tabes dorsalis.*

With:

A. Tabetic crises occurring more frequently than once monthly; or

B. Unsteady, broad-based or ataxic gait causing significant restriction of mobility substantiated by appropriate posterior column signs.

11.16 *Subacute combined cord degeneration (pernicious anemia) with disorganization of motor function as described in 11.04B or 11.15B, not significantly improved by prescribed treatment.*

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

A. Disorganization of motor function as described in 11.04B or 11.15B; or

B. Chronic brain syndrome. Evaluate under 12.02.

11.18 *Cerebral trauma:*

Evaluate under the provisions of 11.02, 11.03, 11.04 and 12.02, as applicable.

11.19 *Syringomyelia.*

With:

A. Significant bulbar signs; or

B. Disorganization of motor function as described in 11.04B.

12.00 MENTAL DISORDERS

The mental disorders listings in 12.00 of the Listing of Impairments will no longer be effective on August 28, 1997, unless extended by the Commissioner or revised and promulgated again.

A. *Introduction:* The evaluation of disability on the basis of mental disorders requires the documentation of a medically determinable impairment(s) as well as consideration of the degree of limitation such impairment(s) may impose on the individual's ability to work and whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. The listings for mental disorders are arranged in eight diagnostic categories: organic mental disorders (12.02); schizophrenic, paranoid and other psychotic disorders (12.03); affective disorders (12.04); mental retardation and autism (12.05); anxiety related disorders (12.06); somatoform disorders (12.07); personality disorders (12.08); and substance addiction disorders (12.09). Each diagnostic group, except listings 12.05 and 12.09, consists of a set of clinical findings (paragraph A criteria), one or more of which must be met, and which, if met, lead to a test of functional restrictions (paragraph B criteria), two or three of which must also be met. There are additional considerations (paragraph C criteria) in listings 12.03 and 12.06, discussed therein.

The purpose of including the criteria in paragraph A of the listings for mental disorders is to medically substantiate the presence of a mental disorder. Specific signs and symptoms under any of the listings 12.02 through 12.09 cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) which is supported by the individual's clinical findings.

The purpose of including the criteria in paragraphs B and C of the listings for mental disorders is to describe those functional limitations associated with mental disorders which are incompatible with the ability to work. The restrictions listed in paragraphs B and C must be the result of the mental disorder which is manifested by the clinical findings outlined in paragraph A. The criteria included in paragraphs B and C of the listings for mental disorders have been chosen because they represent functional areas deemed essential to work. An individual who is severely limited in these areas as the result of an impairment identified in paragraph A is presumed to be unable to work.

The structure of the listing for substance addiction disorders, listing 12.09, is different from that for the other mental disorder listings. Listing 12.09 is structured as a reference listing; that is, it will only serve to

indicate which of the other listed mental or physical impairments must be used to evaluate the behavioral or physical changes resulting from regular use of addictive substances.

The listings for mental disorders are so constructed that an individual meeting or equaling the criteria could not reasonably be expected to engage in gainful work activity.

Individuals who have an impairment with a level of severity which does not meet the criteria of the listings for mental disorders may or may not have the residual functional capacity (RFC) which would enable them to engage in substantial gainful work activity. The determination of mental RFC is crucial to the evaluation of an individual's capacity to engage in substantial gainful work activity when the criteria of the listings for mental disorders are not met or equalled but the impairment is nevertheless severe.

RFC may be defined as a multidimensional description of the work-related abilities which an individual retains in spite of medical impairments. RFC complements the criteria in paragraphs B and C of the listings for mental disorders by requiring consideration of an expanded list of work-related capacities which may be impaired by mental disorder when the impairment is severe but does not meet or equal a listed mental disorder.

B. Need for Medical Evidence: The existence of a medically determinable impairment of the required duration must be established by medical evidence consisting of clinical signs, symptoms and/or laboratory or psychological test findings. These findings may be intermittent or persistent depending on the nature of the disorder. Clinical signs are medically demonstrable phenomena which reflect specific abnormalities of behavior, affect, thought, memory, orientation, or contact with reality. These signs are typically assessed by a psychiatrist or psychologist and/or documented by psychological tests. Symptoms are complaints presented by the individual. Signs and symptoms generally cluster together to constitute recognizable clinical syndromes (mental disorders). Both symptoms and signs which are part of any diagnosed mental disorder must be considered in evaluating severity.

C. Assessment of Severity: For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph B of the listings for mental disorders (descriptions of restrictions of activities of daily living; social functioning; concentration, persistence, or pace; and ability to tolerate increased mental demands associated with competitive work). Where "marked" is used as a standard for measuring the degree of limitation, it means more than moderate, but less than extreme. A marked limitation

may arise when several activities or functions are impaired or even when only one is impaired, so long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately and effectively. Four areas are considered.

1. *Activities of daily living* include adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for one's grooming and hygiene, using telephones and directories, using a post office, etc. In the context of the individual's overall situation, the quality of these activities is judged by their independence, appropriateness and effectiveness. It is necessary to define the extent to which the individual is capable of initiating and participating in activities independent of supervision or direction.

"Marked" is not the number of activities which are restricted but the overall degree of restriction or combination of restrictions which must be judged. For example, a person who is able to cook and clean might still have marked restrictions of daily activities if the person were too fearful to leave the immediate environment of home and neighborhood, hampering the person's ability to obtain treatment or to travel away from the immediate living environment.

2. *Social functioning* refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. Social functioning includes the ability to get along with others, e.g., family members, friends, neighbors, grocery clerks, landlords, bus drivers, etc. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, etc. Strength in social functioning may be documented by an individual's ability to initiate social contacts with others, communicate clearly with others, interact and actively participate in group activities, etc. Cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity also need to be considered. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority, e.g., supervisors, or cooperative behaviors involving coworkers.

"Marked" is not the number of areas in which social functioning is impaired, but the overall degree of interference in a particular area or combination of areas of functioning. For example, a person who is highly antagonistic, uncooperative or hostile but is tolerated by local storekeepers may nevertheless have marked restrictions in social functioning because that behavior is not acceptable in other social contexts.

3. *Concentration, persistence and pace* refer to the ability to sustain focused attention

sufficiently long to permit the timely completion of tasks commonly found in work settings. In activities of daily living, concentration may be reflected in terms of ability to complete tasks in everyday household routines. Deficiencies in concentration, persistence and pace are best observed in work and work-like settings. Major impairment in this area can often be assessed through direct psychiatric examination and/or psychological testing, although mental status examination or psychological test data alone should not be used to accurately describe concentration and sustained ability to adequately perform work-like tasks. On mental status examinations, concentration is assessed by tasks such as having the individual subtract serial sevens from 100. In psychological tests of intelligence or memory, concentration is assessed through tasks requiring short-term memory or through tasks that must be completed within established time limits. In work evaluations, concentration, persistence, and pace are assessed through such tasks as filing index cards, locating telephone numbers, or disassembling and reassembling objects. Strengths and weaknesses in areas of concentration can be discussed in terms of frequency of errors, time it takes to complete the task, and extent to which assistance is required to complete the task.

4. *Deterioration or decompensation in work or work-like settings* refers to repeated failure to adapt to stressful circumstances which cause the individual either to withdraw from that situation or to experience exacerbation of signs and symptoms (i.e., decompensation) with an accompanying difficulty in maintaining activities of daily living, social relationships, and/or maintaining concentration, persistence, or pace (i.e., deterioration which may include deterioration of adaptive behaviors). Stresses common to the work environment include decisions, attendance, schedules, completing tasks, interactions with supervisors, interactions with peers, etc.

D. Documentation: The presence of a mental disorder should be documented primarily on the basis of reports from individual providers, such as psychiatrists and psychologists, and facilities such as hospitals and clinics. Adequate descriptions of functional limitations must be obtained from these or other sources which may include programs and facilities where the individual has been observed over a considerable period of time.

Information from both medical and non-medical sources may be used to obtain detailed descriptions of the individual's activities of daily living; social functioning; concentration, persistence and pace; or ability to tolerate increased mental demands (stress). This information can be provided by programs such as community mental health centers, day care centers, sheltered workshops, etc. It can also be provided by others,

including family members, who have knowledge of the individual's functioning. In some cases descriptions of activities of daily living or social functioning given by individuals or treating sources may be insufficiently detailed and/or may be in conflict with the clinical picture otherwise observed or described in the examinations or reports. It is necessary to resolve any inconsistencies or gaps that may exist in order to obtain a proper understanding of the individual's functional restrictions.

An individual's level of functioning may vary considerably over time. The level of functioning at a specific time may seem relatively adequate or, conversely, rather poor. Proper evaluation of the impairment must take any variations in level of functioning into account in arriving at a determination of impairment severity over time. Thus, it is vital to obtain evidence from relevant sources over a sufficiently long period prior to the date of adjudication in order to establish the individual's impairment severity. This evidence should include treatment notes, hospital discharge summaries, and work evaluation or rehabilitation progress notes if these are available.

Some individuals may have attempted to work or may actually have worked during the period of time pertinent to the determination of disability. This may have been an independent attempt at work, or it may have been in conjunction with a community mental health or other sheltered program which may have been of either short or long duration. Information concerning the individual's behavior during any attempt to work and the circumstances surrounding termination of the work effort are particularly useful in determining the individual's ability or inability to function in a work setting.

The results of well-standardized psychological tests such as the Wechsler Adult Intelligence Scale (WAIS), the Minnesota Multiphasic Personality Inventory (MMPI), the Rorschach, and the Thematic Apperception Test (TAT), may be useful in establishing the existence of a mental disorder. For example, the WAIS is useful in establishing mental retardation, and the MMPI, Rorschach, and TAT may provide data supporting several other diagnoses. Broad-based neuropsychological assessments using, for example, the Halstead-Reitan or the Luria-Nebraska batteries may be useful in determining brain function deficiencies, particularly in cases involving subtle findings such as may be seen in traumatic brain injury. In addition, the process of taking a standardized test requires concentration, persistence and pace; performance on such tests may provide useful data. Test results should, therefore, include both the objective data and a narrative description of clinical findings. Narrative reports of intellectual assessment should include a discussion of whether

or not obtained IQ scores are considered valid and consistent with the individual's developmental history and degree of functional restriction.

In cases involving impaired intellectual functioning, a standardized intelligence test, e.g., the WAIS, should be administered and interpreted by a psychologist or psychiatrist qualified by training and experience to perform such an evaluation. In special circumstances, nonverbal measures, such as the Raven Progressive Matrices, the Leiter International scale, or the Arthur adaptation of the Leiter may be substituted.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. In this connection, it must be noted that on the WAIS, for example, IQs of 70 and below are characteristic of approximately the lowest 2 percent of the general population. In instances where other tests are administered, it would be necessary to convert the IQ to the corresponding percentile rank in the general population in order to determine the actual degree of impairment reflected by those IQ scores.

In cases where more than one IQ is customarily derived from the test administered, i.e., where verbal, performance, and full-scale IQs are provided as on the WAIS, the lowest of these is used in conjunction with listing 12.05.

In cases where the nature of the individual's intellectual impairment is such that standard intelligence tests, as described above, are precluded, medical reports specifically describing the level of intellectual, social, and physical function should be obtained. Actual observations by Social Security Administration or State agency personnel, reports from educational institutions and information furnished by public welfare agencies or other reliable objective sources should be considered as additional evidence.

E. Chronic Mental Impairments: Particular problems are often involved in evaluating mental impairments in individuals who have long histories of repeated hospitalizations or prolonged outpatient care with supportive therapy and medication. Individuals with chronic psychotic disorders commonly have their lives structured in such a way as to minimize stress and reduce their signs and symptoms. Such individuals may be much more impaired for work than their signs and symptoms would indicate. The results of a single examination may not adequately describe these individuals' sustained ability to function. It is, therefore, vital to review all pertinent information relative to the individual's condition, especially at times of increased stress. It is mandatory to attempt to obtain adequate descriptive information from all sources which have treated the individual either currently or in the time period relevant to the decision.

F. Effects of Structured Settings: Particularly in cases involving chronic mental disorders, overt symptomatology may be controlled or attenuated by psychosocial factors such as placement in a hospital, board and care facility, or other environment that provides similar structure. Highly structured and supportive settings may greatly reduce the mental demands placed on an individual. With lowered mental demands, overt signs and symptoms of the underlying mental disorder may be minimized. At the same time, however, the individual's ability to function outside of such a structured and/or supportive setting may not have changed. An evaluation of individuals whose symptomatology is controlled or attenuated by psychosocial factors must consider the ability of the individual to function outside of such highly structured settings. (For these reasons the paragraph C criteria were added to Listings 12.03 and 12.06.)

G. Effects of Medication: Attention must be given to the effect of medication on the individual's signs, symptoms and ability to function. While psychotropic medications may control certain primary manifestations of a mental disorder, e.g., hallucinations, such treatment may or may not affect the functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the psychotropic medications, particular attention must be focused on the functional restrictions which may persist. These functional restrictions are also to be used as the measure of impairment severity. (See the paragraph C criteria in Listings 12.03 and 12.06.)

Neuroleptics, the medicines used in the treatment of some mental illnesses, may cause drowsiness, blunted affect, or other side effects involving other body systems. Such side effects must be considered in evaluating overall impairment severity. Where adverse effects of medications contribute to the impairment severity and the impairment does not meet or equal the listings but is nonetheless severe, such adverse effects must be considered in the assessment of the mental residual functional capacity.

H. Effect of Treatment: It must be remembered that with adequate treatment some individuals suffering with chronic mental disorders not only have their symptoms and signs ameliorated but also return to a level of function close to that of their premorbid status. Our discussion here in 12.00H has been designed to reflect the fact that present day treatment of a mentally impaired individual may or may not assist in the achievement of an adequate level of adaptation required in the work place. (See the paragraph C criteria in Listings 12.03 and 12.06.)

I. Technique for Reviewing the Evidence in Mental Disorders Claims to Determine Level of Impairment Severity: A special technique has been developed to ensure that all evidence

needed for the evaluation of impairment severity in claims involving mental impairment is obtained, considered and properly evaluated. This technique, which is used in connection with the sequential evaluation process, is explained in §404.1520a and §416.920a.

12.01 Category of Impairments-Mental
12.02 Organic Mental Disorders: Psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Demonstration of a loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one of the following:

1. Disorientation to time and place; or
2. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or
3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or
4. Change in personality; or
5. Disturbance in mood; or
6. Emotional lability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or
7. Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., the Luria-Nebraska, Halstead-Reitan, etc.;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.03 Schizophrenic, Paranoid and Other Psychotic Disorders: Characterized by the onset of psychotic features with deterioration from a previous level of functioning.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or
2. Catatonic or other grossly disorganized behavior; or
3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:

- a. Blunt affect; or
- b. Flat affect; or
- c. Inappropriate affect;

or

4. Emotional withdrawal and/or isolation;
 AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors);

OR

C. Medically documented history of one or more episodes of acute symptoms, signs and functional limitations which at the time met the requirements in A and B of this listing, although these symptoms or signs are currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of deterioration or decompensation in situations which cause the individual to withdraw from that situation or to experience exacerbation of signs or symptoms (which may include deterioration of adaptive behaviors); or
2. Documented current history of two or more years of inability to function outside of a highly supportive living situation.

12.04 Affective Disorders: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

- a. Anhedonia or pervasive loss of interest in almost all activities; or
- b. Appetite disturbance with change in weight; or
- c. Sleep disturbance; or
- d. Psychomotor agitation or retardation; or
- e. Decreased energy; or
- f. Feelings of guilt or worthlessness; or
- g. Difficulty concentrating or thinking; or
- h. Thoughts of suicide; or
- i. Hallucinations, delusions, or paranoid thinking; or
- 2. Manic syndrome characterized by at least three of the following:
 - a. Hyperactivity; or
 - b. Pressure of speech; or
 - c. Flight of ideas; or
 - d. Inflated self-esteem; or
 - e. Decreased need for sleep; or
 - f. Easy distractibility; or
 - g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
 - h. Hallucinations, delusions or paranoid thinking; or

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:

- 1. Marked restriction of activities of daily living; or
- 2. Marked difficulties in maintaining social functioning; or
- 3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
- 4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.05 *Mental Retardation and Autism*: Mental retardation refers to a significantly sub-average general intellectual functioning with deficits in adaptive behavior initially manifested during the developmental period (before age 22). (Note: The scores specified below refer to those obtained on the WAIS, and are used only for reference purposes. Scores obtained on other standardized and individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning.) Autism is a pervasive developmental disorder characterized by social and significant communication deficits originating in the developmental period.

The required level of severity for this disorder is met when the requirements in A, B, C, or D are satisfied.

A. Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded;

OR

B. A valid verbal, performance, or full scale IQ of 59 or less;

OR

C. A valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing additional and significant work-related limitation of function;

OR

D. A valid verbal, performance, or full scale IQ of 60 through 70, or in the case of autism, gross deficits of social and communicative skills, with either condition resulting in two of the following:

- 1. Marked restriction of activities of daily living; or
- 2. Marked difficulties in maintaining social functioning; or
- 3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
- 4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.06 *Anxiety Related Disorders*: In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied.

A. Medically documented findings of at least one of the following:

- 1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:
 - a. Motor tension; or
 - b. Autonomic hyperactivity; or
 - c. Apprehensive expectation; or
 - d. Vigilance and scanning;

or

- 2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

4. Recurrent obsessions or compulsions which are a source of marked distress; or

5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors);

OR

C. Resulting in complete inability to function independently outside the area of one's home.

12.07 *Somatoform Disorders*: Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented by evidence of one of the following:

- 1. A history of multiple physical symptoms of several years duration, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly; or
- 2. Persistent nonorganic disturbance of one of the following:
 - a. Vision; or
 - b. Speech; or
 - c. Hearing; or
 - d. Use of a limb; or
 - e. Movement and its control (e.g., coordination disturbance, psychogenic seizures, akinesia, dyskinesia; or
 - f. Sensation (e.g., diminished or heightened).

3. Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury;

AND

B. Resulting in three of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behavior).

12.08 *Personality Disorders*: A personality disorder exists when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress. Characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Deeply ingrained, maladaptive patterns of behavior associated with one of the following:

- 1. Seclusiveness or autistic thinking; or
- 2. Pathologically inappropriate suspiciousness or hostility; or
- 3. Oddities of thought, perception, speech and behavior; or
- 4. Persistent disturbances of mood or affect; or
- 5. Pathological dependence, passivity, or aggressiveness; or
- 6. Intense and unstable interpersonal relationships and impulsive and damaging behavior;

AND

B. Resulting in three of the following:

- 1. Marked restriction of activities of daily living; or
- 2. Marked difficulties in maintaining social functioning; or
- 3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
- 4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.09 *Substance Addiction Disorders*: Behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system.

The required level of severity for these disorders is met when the requirements in any of the following (A through I) are satisfied.

A. Organic mental disorders. Evaluate under 12.02.

B. Depressive syndrome. Evaluate under 12.04.

C. Anxiety disorders. Evaluate under 12.06.

D. Personality disorders. Evaluate under 12.08.

- E. Peripheral neuropathies. Evaluate under 11.14.
- F. Liver damage. Evaluate under 5.05.
- G. Gastritis. Evaluate under 5.04.
- H. Pancreatitis. Evaluate under 5.08.
- I. Seizures. Evaluate under 11.02 or 11.03.

13.00 NEOPLASTIC DISEASES, MALIGNANT

A. *Introduction:* The determination of the level of impairment resulting from malignant tumors is made from a consideration of the site of the lesion, the histogenesis of the tumor, the extent of involvement, the apparent adequacy and response to therapy (surgery, irradiation, hormones, chemotherapy, etc.), and the magnitude of the post therapeutic residuals.

B. *Documentation:* The diagnosis of malignant tumors should be established on the basis of symptoms, signs, and laboratory findings. The site of the primary, recurrent, and metastatic lesion must be specified in all cases of malignant neoplastic diseases. If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen. If these documents are not obtainable, then the summary of hospitalization or a report from the treating physician must include details of the findings at surgery and the results of the pathologist's gross and microscopic examination of the tissues.

For those cases in which a disabling impairment was not established when therapy was begun but progression of the disease is likely, current medical evidence should include a report of a recent examination directed especially at local or regional recurrence, soft part or skeletal metastases, and significant posttherapeutic residuals.

C. *Evaluation.* Usually, when the malignant tumor consists of a local lesion with metastases to the regional lymph nodes which apparently has been completely excised, imminent recurrence or metastases is not anticipated. A number of exceptions are noted in the specific Listings. For adjudicative purposes, "distant metastases" or "metastases beyond the regional lymph nodes" refers to metastasis beyond the lines of the usual radical en bloc resection.

Local or regional recurrence after radical surgery or pathological evidence of incomplete excision by radical surgery is to be equated with unresectable lesions (except for carcinoma of the breast, 13.09C) and, for the purposes of our program, may be evaluated as "inoperable."

Local or regional recurrence after incomplete excision of a localized and still completely resectable tumor is not to be equated with recurrence after radical surgery. In the evaluation of lymphomas, the tissue type and site of involvement are not necessarily indicators of the degree of impairment.

When a malignant tumor has metastasized beyond the regional lymph nodes, the impairment will usually be found to meet the requirements of a specific listing. Exceptions are hormone-dependent tumors, isotope-sensitive metastases, and metastases from seminoma of the testicles which are controlled by definitive therapy.

When the original tumor and any metastases have apparently disappeared and have not been evident for 3 or more years, the impairment does not meet the criteria under this body system.

D. *Effects of therapy.* Significant posttherapeutic residuals, not specifically included in the category of impairments for malignant neoplasms, should be evaluated according to the affected body system.

Where the impairment is not listed in the Listing of Impairments and is not medically equivalent to a listed impairment, the impact of any residual impairment including that caused by therapy must be considered. The therapeutic regimen and consequent adverse response to therapy may vary widely; therefore, each case must be considered on an individual basis. It is essential to obtain a specific description of the therapeutic regimen, including the drugs given, dosage, frequency of drug administration, and plans for continued drug administration. It is necessary to obtain a description of the complications or any other adverse response to therapy such as nausea, vomiting, diarrhea, weakness, dermatologic disorders, or reactive mental disorders. Since the severity of the adverse effects of anticancer chemotherapy may change during the period of drug administration, the decision regarding the impact of drug therapy should be based on a sufficient period of therapy to permit proper consideration.

E. *Onset.* To establish onset of disability prior to the time a malignancy is first demonstrated to be inoperable or beyond control by other modes of therapy (and prior evidence is nonexistent) requires medical judgment based on medically reported symptoms, the type of the specific malignancy, its location, and extent of involvement when first demonstrated.

13.01 Category of Impairments, Neoplastic Diseases—Malignant

13.02 *Head and neck* (except salivary glands—13.07, thyroid gland—13.08, and mandible, maxilla, orbit, or temporal fossa—13.11):

- A. Inoperable; or
- B. Not controlled by prescribed therapy; or
- C. Recurrent after radical surgery or irradiation; or
- D. With distant metastases; or
- E. Epidermoid carcinoma occurring in the pyriform sinus or posterior third of the tongue.

13.03 *Sarcoma of skin:*

Social Security Administration

A. Angiosarcoma with metastases to regional lymph nodes or beyond; or

B. Mycosis fungoides with metastases to regional lymph nodes, or with visceral involvement.

13.04 *Sarcoma of soft parts:* Not controlled by prescribed therapy.

13.05 *Malignant melanoma:*

- A. Recurrent after wide excision; or
- B. With metastases to adjacent skin (satellite lesions) or elsewhere.

13.06 *Lymph nodes:*

- A. Hodgkin's disease or non-Hodgkin's lymphoma with progressive disease not controlled by prescribed therapy; or
- B. Metastatic carcinoma in a lymph node (except for epidermoid carcinoma in a lymph node in the neck) where the primary site is not determined after adequate search; or
- C. Epidermoid carcinoma in a lymph node in the neck not responding to prescribed therapy.

13.07 *Salivary glands*—carcinoma or sarcoma with metastases beyond the regional lymph nodes.

13.08 *Thyroid gland*—carcinoma with metastases beyond the regional lymph nodes, not controlled by prescribed therapy.

13.09 *Breast:*

- A. Inoperable carcinoma; or
- B. Inflammatory carcinoma; or
- C. Recurrent carcinoma, except local recurrence controlled by prescribed therapy; or
- D. Distant metastases from breast carcinoma (bilateral breast carcinoma, synchronous or metachronous is usually primary in each breast); or
- E. Sarcoma with metastases anywhere.

13.10 *Skeletal system* (exclusive of the jaw):

- A. Malignant primary tumors with evidence of metastases and not controlled by prescribed therapy; or
- B. Metastatic carcinoma to bone where the primary site is not determined after adequate search.

13.11 *Mandible, maxilla, orbit, or temporal fossa:*

- A. Sarcoma of any type with metastases; or
- B. Carcinoma of the antrum with extension into the orbit or ethmoid or sphenoid sinus, or with regional or distant metastases; or
- C. Orbital tumors with intracranial extension; or
- D. Tumors of the temporal fossa with perforation of skull and meningeal involvement; or
- E. Adamantinoma with orbital or intracranial infiltration; or
- F. Tumors of Rathke's pouch with infiltration of the base of the skull or metastases.

13.12 *Brain or spinal cord:*

A. Metastatic carcinoma to brain or spinal cord.

- B. Evaluate other tumors under the criteria described in 11.05 and 11.08.
- 13.13 *Lungs.*

- A. Unresectable or with incomplete excision; or
- B. Recurrence or metastases after resection; or
- C. Oat cell (small cell) carcinoma; or
- D. Squamous cell carcinoma, with metastases beyond the hilar lymph nodes; or
- E. Other histologic types of carcinoma, including undifferentiated and mixed-cell types (but excluding oat cell carcinoma, 13.13C, and squamous cell carcinoma, 13.13D), with metastases to the hilar lymph nodes.

13.14 *Pleura or mediastinum:*

- A. Malignant mesothelioma of pleura; or
- B. Malignant tumors, metastatic to pleura; or
- C. Malignant primary tumor of the mediastinum not controlled by prescribed therapy.

- 13.15 *Abdomen:*
 - A. Generalized carcinomatosis; or
 - B. Retroperitoneal cellular sarcoma not controlled by prescribed therapy; or
 - C. Ascites with demonstrated malignant cells.
- 13.16 *Esophagus or stomach:*
 - A. Carcinoma or sarcoma of the esophagus; or
 - B. Carcinoma of the stomach with metastases to the regional lymph nodes or extension to surrounding structure; or
 - C. Sarcoma of stomach not controlled by prescribed therapy; or
 - D. Inoperable carcinoma; or
 - E. Recurrence or metastases after resection.

13.17 *Small intestine:*

- A. Carcinoma, sarcoma, or carcinoid tumor with metastases beyond the regional lymph nodes; or
- B. Recurrence of carcinoma, sarcoma, or carcinoid tumor after resection; or
- C. Sarcoma, not controlled by prescribed therapy.

13.18 *Large intestine* (from ileocecal valve to and including anal canal)—carcinoma or sarcoma.

- A. Unresectable; or
- B. Metastases beyond the regional lymph nodes; or
- C. Recurrence or metastases after resection.

13.19 *Liver or gallbladder:*

- A. Primary or metastatic malignant tumors of the liver; or
- B. Carcinoma of the gallbladder; or
- C. Carcinoma of the bile ducts.

13.20 *Pancreas:*

- A. Carcinoma except islet cell carcinoma; or
- B. Islet cell carcinoma which is unresectable and physiologically active.

13.21 *Kidneys, adrenal glands, or ureters—carcinoma:*

- A. Unresectable; or
- B. With hematogenous spread to distant sites; or

C. With metastases to regional lymph nodes.

13.22 *Urinary bladder—carcinoma.* With:

- A. Infiltration beyond the bladder wall; or
- B. Metastases to regional lymph nodes; or
- C. Unresectable; or
- D. Recurrence after total cystectomy; or
- E. Evaluate renal impairment after total cystectomy under the criteria in 6.02.

13.23 *Prostate gland—carcinoma* not controlled by prescribed therapy.

13.24 *Testicles:*

- A. Choriocarcinoma; or
- B. Other malignant primary tumors with progressive disease not controlled by prescribed therapy.

13.25 *Uterus—carcinoma or sarcoma* (corpus or cervix).

- A. Inoperable and not controlled by prescribed therapy; or
- B. Recurrent after total hysterectomy; or
- C. Total pelvic exenteration

13.26 *Ovaries—all malignant, primary or recurrent tumors.* With:

- A. Ascites with demonstrated malignant cells; or
- B. Unresectable infiltration; or
- C. Unresectable metastases to omentum or elsewhere in the peritoneal cavity; or
- D. Distant metastases.

13.27 *Leukemia:* Evaluate under the criteria of 7.00ff, Hemic and Lymphatic Sytem.

13.28 *Uterine (Fallopian) tubes—carcinoma or sarcoma:*

- A. Unresectable, or
- B. Metastases to regional lymph nodes.

13.29 *Penis—carcinoma with metastases to regional lymph nodes.*

13.30 *Vulva—carcinoma, with distant metastases.*

14.00 IMMUNE SYSTEM

A. Listed disorders include impairments involving deficiency of one or more components of the immune system (i.e., antibody-producing B cells; a number of different types of cells associated with cell-mediated immunity including T-lymphocytes, macrophages and monocytes; and components of the complement system).

B. Dysregulation of the immune system may result in the development of a connective tissue disorder. Connective tissue disorders include several chronic multisystem disorders that differ in their clinical manifestation, course, and outcome. They generally evolve and persist for months or years, may result in loss of functional abilities, and may require long-term, repeated evaluation and management.

The documentation needed to establish the existence of a connective tissue disorder is medical history, physical examination, selected laboratory studies, medically acceptable imaging techniques and, in some instances, tissue biopsy. However, the Social Security Administration will not purchase

diagnostic tests or procedures that may involve significant risk, such as biopsies or angiograms. Generally, the existing medical evidence will contain this information.

A longitudinal clinical record of at least 3 months demonstrating active disease despite prescribed treatment during this period with the expectation that the disease will remain active for 12 months is necessary for assessment of severity and duration of impairment.

To permit appropriate application of a listing, the specific diagnostic features that should be documented in the clinical record for each of the disorders are summarized for systemic lupus erythematosus (SLE), systemic vasculitis, systemic sclerosis and scleroderma, polymyositis or dermatomyositis, and undifferentiated connective tissue disorders.

In addition to the limitations caused by the connective tissue disorder *per se*, the chronic adverse effects of treatment (e.g., corticosteroid-related ischemic necrosis of bone) may result in functional loss.

These disorders may preclude performance of any gainful activity by reason of severe loss of function in a single organ or body system, or lesser degrees of functional loss in two or more organs/body systems associated with significant constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. We use the term "severe" in these listings to describe medical severity; the term does not have the same meaning as it does when we use it in connection with a finding at the second step of the sequential evaluation processes in §§404.1520, 416.920, and 416.924.

1. Systemic lupus erythematosus (14.02)—This disease is characterized clinically by constitutional symptoms and signs (e.g., fever, fatigability, malaise, weight loss), multisystem involvement and, frequently, anemia, leukopenia, or thrombocytopenia. Immunologically, an array of circulating serum auto-antibodies can occur, but are highly variable in pattern. Generally the medical evidence will show that patients with this disease will fulfill The 1982 Revised Criteria for the Classification of Systemic Lupus Erythematosus of the American College of Rheumatology. (Tan, E.M., et al., *Arthritis Rheum.* 25: 1271-1277, 1982).

2. Systemic vasculitis (14.03)—This disease occurs acutely in association with adverse drug reactions, certain chronic infections and, occasionally, malignancies. More often it is idiopathic and chronic. There are several clinical patterns, including classical polyarteritis nodosa, aortic arch arteritis, giant cell arteritis, Wegener's granulomatosis, and vasculitis associated with other connective tissue disorders (e.g., rheumatoid arthritis, SLE, Sjögren's syndrome, cryoglobulinemia). Cutaneous vasculitis may

or may not be associated with systemic involvement and the patterns of vascular and ischemic involvement are highly variable. The diagnosis is confirmed by angiography or tissue biopsy when the disease is suspected clinically. Most patients who are stated to have this disease will have the results of the confirmatory angiogram or biopsy in their medical records.

3. Systemic sclerosis and scleroderma (14.04)—These disorders constitute a spectrum of disease in which thickening of the skin is the clinical hallmark. Raynaud's phenomena, often severe and progressive, are especially frequent and may be the peripheral manifestation of a generalized vasospastic abnormality in the heart, lungs, and kidneys. The CREST syndrome (calcinosis, Raynaud's phenomena, esophageal dysmotility, sclerodactyly, telangiectasia) is a variant that may slowly progress to the generalized process, systemic sclerosis, over years. In addition to skin and blood vessels, the major organ/body system involvement includes the gastrointestinal tract, lungs, heart, kidneys, and muscle. Although arthritis can occur, joint dysfunction results primarily from soft tissue/cutaneous thickening, fibrosis, and contractures.

4. Polymyositis or dermatomyositis (14.05)—This disorder is primarily an inflammatory process in striated muscle, which can occur alone or in association with other connective tissue disorders or malignancy. Weakness and, less frequently, pain and tenderness of the proximal limb-girdle musculature are the cardinal manifestations. Involvement of the cervical muscles, the cricopharyngeals, the intercostals, and diaphragm may occur in those with listing-level disease. Weakness of the pelvic girdle, as contemplated in Listing 14.05A, may result in significant difficulty climbing stairs or rising from a chair without use of the arms. Proximal limb weakness in the upper extremities may result in inability to lift objects, and interference with dressing and combing hair. Weakness of anterior neck flexors may impair the ability to lift the head from the pillow in bed. The diagnosis is supported by elevated serum muscle enzymes (creatinine phosphokinase (CPK), aminotransferases, aldolase), characteristic abnormalities on electromyography, and myositis on muscle biopsy.

5. Undifferentiated connective tissue disorder (14.06)—This listing includes syndromes with clinical and immunologic features of several connective tissue disorders, but that do not satisfy the criteria for any of the disorders described; for instance, the individual may have clinical features of systemic lupus erythematosus and systemic vasculitis and the serologic findings of rheumatoid arthritis. It also includes overlap syndromes with clinical features of more than one established connective tissue dis-

order. For example, the individual may have features of both rheumatoid arthritis and scleroderma. The correct designation of this disorder is important for assessment of prognosis.

C. Allergic disorders (e.g., asthma or atopic dermatitis) are discussed and evaluated under the appropriate listing of the affected body system.

D. Human immunodeficiency virus (HIV) infection.

1. HIV infection is caused by a specific retrovirus and may be characterized by susceptibility to one or more opportunistic diseases, cancers, or other conditions, as described in 14.08. Any individual with HIV infection, including one with a diagnosis of acquired immunodeficiency syndrome (AIDS), may be found disabled under this listing if his or her impairment meets any of the criteria in 14.08 or is of equivalent severity to any impairment in 14.08.

2. Definitions. In 14.08, the terms "resistant to treatment," "recurrent," and "disseminated" have the same general meaning as used by the medical community. The precise meaning of any of these terms will depend upon the specific disease or condition in question, the body system affected, the usual course of the disorder and its treatment, and the other circumstances of the case.

"Resistant to treatment" means that a condition did not respond adequately to an appropriate course of treatment. Whether a response is adequate, or a course of treatment appropriate, will depend on the facts of the particular case.

"Recurrent" means that a condition that responded adequately to an appropriate course of treatment has returned after a period of remission or regression. The extent of response (or remission) and the time periods involved will depend on the facts of the particular case.

"Disseminated" means that a condition is spread widely over a considerable area or body system(s). The type and extent of the spread will depend on the specific disease.

As used in 14.08I, "significant involuntary weight loss" does not correspond to a specific minimum amount or percentage of weight loss. Although, for purposes of this listing, an involuntary weight loss of at least 10 percent of baseline is always considered significant, loss of less than 10 percent may or may not be significant, depending on the individual's baseline weight and body habitus. (For example, a 7-pound weight loss in a 100-pound female who is 63 inches tall might be considered significant; but a 14-pound weight loss in a 200-pound female who is the same height might not be significant.)

3. Documentation of HIV infection. The medical evidence must include documentation of HIV infection. Documentation may

be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

a. Documentation of HIV infection by definitive diagnosis. A definitive diagnosis of HIV infection is documented by one or more of the following laboratory tests:

i. A serum specimen that contains HIV antibodies. HIV antibodies are usually detected by a screening test. The most commonly used screening test is the ELISA. Although this test is highly sensitive, it may yield false positive results. Therefore, positive results from an ELISA must be confirmed by a more definitive test (e.g., Western blot, immunofluorescence assay).

ii. A specimen that contains HIV antigen (e.g., serum specimen, lymphocyte culture, or cerebrospinal fluid (CSF) specimen).

iii. Other test(s) that are highly specific for detection of HIV (e.g., polymerase chain reaction (PCR)), or that are acceptable methods of detection consistent with the prevailing state of medical knowledge.

When laboratory testing for HIV infection has been performed, every reasonable effort must be made to obtain reports of the results of that testing.

Individuals who have HIV infection or other disorders of the immune system may undergo tests to determine T-helper lymphocyte (CD4) counts. The extent of immune depression correlates with the level or rate of decline of the CD4 count. In general, when the CD4 count is 200/mm³ or less (14 percent or less), the susceptibility to opportunistic disease is considerably increased. However, a reduced CD4 count alone does not establish a definitive diagnosis of HIV infection, or document the severity or functional effects of HIV infection.

b. Other acceptable documentation of HIV infection.

HIV infection may also be documented without the definitive laboratory evidence described in paragraph a, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence. If no definitive laboratory evidence is available, HIV infection may be documented by the medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence. For example, a diagnosis of HIV infection will be accepted without definitive laboratory evidence if the individual has an opportunistic disease (e.g., toxoplasmosis of the brain, pneumocystis carinii pneumonia (PCP)) predictive of a defect in cell-mediated immunity, and there is no other known cause of diminished resistance to that disease (e.g., long-term steroid treatment, lymphoma). In such cases, every reasonable effort must be made to obtain full details of the history, medical findings, and results of testing.

4. Documentation of the manifestations of HIV infection. The medical evidence must also include documentation of the manifestations of HIV infection. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

a. Documentation of the manifestations of HIV infection by definitive diagnosis.

The definitive method of diagnosing opportunistic diseases or conditions that are manifestations of HIV infection is by culture, serological test, or microscopic examination of biopsied tissue or other material (e.g., bronchial washings). Therefore, every reasonable effort must be made to obtain specific laboratory evidence of an opportunistic disease or other condition whenever this information is available. If a histological or other test has been performed, the evidence should include a copy of the appropriate report. If the report is not obtainable, the summary of hospitalization or a report from the treating source should include details of the findings and results of the diagnostic studies (including radiographic studies) or microscopic examination of the appropriate tissues or body fluids.

Although a reduced CD4 lymphocyte count may show that there is an increased susceptibility to opportunistic infections and diseases (see 14.00D3a, above), that alone does not establish the presence, severity, or functional effects of a manifestation of HIV infection.

b. Other acceptable documentation of the manifestations of HIV infection.

Manifestations of HIV infection may also be documented without the definitive laboratory evidence described in paragraph a, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence. If no definitive laboratory evidence is available, manifestations of HIV infection may be documented by medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence. In such cases, every reasonable effort must be made to obtain full details of the history, medical findings, and results of testing.

Documentation of cytomegalovirus (CMV) disease (14.08D) presents special problems because diagnosis requires identification of viral inclusion bodies or a positive culture from the affected organ, and the absence of any other infectious agent. A positive serology test identifies infection with the virus, but does not confirm a disease process. With the exception of chorioretinitis (which may be diagnosed by an ophthalmologist), documentation of CMV disease requires confirmation by biopsy or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

5. Manifestations specific to women. Most women with severe immunosuppression secondary to HIV infection exhibit the typical opportunistic infections and other conditions, such as pneumocystis carinii pneumonia (PCP), candida esophagitis, wasting syndrome, cryptococcosis, and toxoplasmosis. However, HIV infection may have different manifestations in women than in men. Adjudicators must carefully scrutinize the medical evidence and be alert to the variety of medical conditions specific to or common in women with HIV infection that may affect their ability to function in the workplace.

Many of these manifestations (e.g., vulvovaginal candidiasis, pelvic inflammatory disease) occur in women with or without HIV infection, but can be more severe or resistant to treatment, or occur more frequently in a woman whose immune system is suppressed. Therefore, when evaluating the claim of a woman with HIV infection, it is important to consider gynecologic and other problems specific to women, including any associated symptoms (e.g., pelvic pain), in assessing the severity of the impairment and resulting functional limitations. Manifestations of HIV infection in women may be evaluated under the specific criteria (e.g., cervical cancer under 14.08E), under an applicable general category (e.g., pelvic inflammatory disease under 14.08A5) or, in appropriate cases, under 14.08N.

6. Evaluation. The criteria in 14.08 do not describe the full spectrum of diseases or conditions manifested by individuals with HIV infection. As in any case, consideration must be given to whether an individual's impairment(s) meets or equals in severity any other listing in appendix 1 of subpart P (e.g., a neoplastic disorder listed in 13.00ff). Although 14.08 includes cross-references to other listings for the more common manifestations of HIV infection, other listings may apply.

In addition, the impact of all impairments, whether or not related to HIV infection, must be considered. For example, individuals with HIV infection may manifest signs and symptoms of a mental impairment (e.g., anxiety, depression), or of another physical impairment. Medical evidence should include documentation of all physical and mental impairments, and the impairment(s) should be evaluated not only under the relevant listing(s) in 14.08, but under any other appropriate listing(s).

It is also important to remember that individuals with HIV infection, like all other individuals, are evaluated under the full five-step sequential evaluation process described in §404.1520 and §416.920. If an individual with HIV infection is working and engaging in substantial gainful activity (SGA), or does not have a severe impairment, the case will be decided at the first or second step of the

sequential evaluation process, and does not require evaluation under these listings. For an individual with HIV infection who is not engaging in SGA and has a severe impairment, but whose impairment(s) does not meet or equal in severity the criteria of a listing, evaluation must proceed through the final steps of the sequential evaluation process (or, as appropriate, the steps in the medical improvement review standard) before any conclusion can be reached on the issue of disability.

7. Effect of treatment. Medical treatment must be considered in terms of its effectiveness in ameliorating the signs, symptoms, and laboratory abnormalities of the specific disorder, or of the HIV infection itself (e.g., antiretroviral agents) and in terms of any side effects of treatment that may further impair the individual.

Response to treatment and adverse or beneficial consequences of treatment may vary widely. For example, an individual with HIV infection who develops pneumonia or tuberculosis may respond to the same antibiotic regimen used in treating individuals without HIV infection, but another individual with HIV infection may not respond to the same regimen. Therefore, each case must be considered on an individual basis, along with the effects of treatment on the individual's ability to function.

A specific description of the drugs or treatment given (including surgery), dosage, frequency of administration, and a description of the complications or response to treatment should be obtained. The effects of treatment may be temporary or long term. As such, the decision regarding the impact of treatment should be based on a sufficient period of treatment to permit proper consideration.

8. Functional criteria. Paragraph N of 14.08 establishes standards for evaluating manifestations of HIV infection that do not meet the requirements listed in 14.08A-M. Paragraph N is applicable for manifestations that are not listed in 14.08A-M, as well as those listed in 14.08A-M that do not meet the criteria of any of the rules in 14.08A-M.

For individuals with HIV infection evaluated under 14.08N, listing-level severity will be assessed in terms of the functional limitations imposed by the impairment. The full impact of signs, symptoms, and laboratory findings on the claimant's ability to function must be considered. Important factors to be considered in evaluating the functioning of individuals with HIV infection include, but are not limited to: symptoms, such as fatigue and pain; characteristics of the illness, such as the frequency and duration of manifestations or periods of exacerbation and remission in the disease course; and the functional impact of treatment for the disease, including the side effects of medication.

As used in 14.08N, "repeated" means that the conditions occur on an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more; or the conditions do not last for 2 weeks but occur substantially more frequently than 3 times in a year or once every 4 months; or they occur less often than an average of 3 times a year or once every 4 months but last substantially longer than 2 weeks.

To meet the criteria in 14.08N, an individual with HIV infection must demonstrate a marked level of restriction in one of three general areas of functioning: activities of daily living; social functioning; and difficulties in completing tasks due to deficiencies in concentration, persistence, or pace. Functional restrictions may result from the impact of the disease process itself on mental or physical functioning, or both. This could result from extended or intermittent symptoms, such as depression, fatigue, or pain, resulting in a limitation of the ability to concentrate, to persevere at a task, or to perform the task at an acceptable rate of speed. Limitations may also result from the side effects of medication.

When "marked" is used as a standard for measuring the degree of functional limitation, it means more than moderate, but less than extreme. A marked limitation does not represent a quantitative measure of the individual's ability to do an activity for a certain percentage of the time. A marked limitation may be present when several activities or functions are impaired or even when only one is impaired. However, an individual need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively. The term "marked" does not imply that the impaired individual is confined to bed, hospitalized, or in a nursing home.

Activities of daily living include, but are not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, and paying bills. An individual with HIV infection who, because of symptoms such as pain imposed by the illness or its treatment, is not able to maintain a household or take public transportation on a sustained basis or without assistance (even though he or she is able to perform some self-care activities) would have marked limitation of activities of daily living.

Social functioning includes the capacity to interact appropriately and communicate effectively with others. An individual with HIV infection who, because of symptoms or a pattern of exacerbation and remission caused by the illness or its treatment, cannot engage in social interaction on a sustained basis (even though he or she is able to com-

municate with close friends or relatives) would have marked difficulty maintaining social functioning.

Completing tasks in a timely manner involves the ability to sustain concentration, persistence, or pace to permit timely completion of tasks commonly found in work settings. An individual with HIV infection who, because of HIV-related fatigue or other symptoms, is unable to sustain concentration or pace adequate to complete simple work-related tasks (even though he or she is able to do routine activities of daily living) would have marked difficulty completing tasks.

14.01 Category of Impairments, Immune System

14.02 Systemic lupus erythematosus. Documented as described in 14.00B1, with:

A. One of the following:

1. Joint involvement, as described under the criteria in 1.00; or
2. Muscle involvement, as described under the criteria in 14.05; or
3. Ocular involvement, as described under the criteria in 2.00ff; or
4. Respiratory involvement, as described under the criteria in 3.00ff; or
5. Cardiovascular involvement, as described under the criteria in 4.00ff or 14.04D; or
6. Digestive involvement, as described under the criteria in 5.00ff; or
7. Renal involvement, as described under the criteria in 6.00ff; or
8. Skin involvement, as described under the criteria in 8.00ff; or
9. Neurological involvement, as described under the criteria in 11.00ff; or
10. Mental involvement, as described under the criteria in 12.00ff.

or

B. Lesser involvement of two or more organs/body systems listed in paragraph A, with significant, documented, constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. At least one of the organs/body systems must be involved to at least a moderate level of severity.

14.03 Systemic vasculitis. Documented as described in 14.00B2, including documentation by angiography or tissue biopsy, with:

A. Involvement of a single organ or body system, as described under the criteria in 14.02A.

or

B. Lesser involvement of two or more organs/body systems listed in 14.02A, with significant, documented, constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. At least one of the organs/body systems must be involved to at least a moderate level of severity.

14.04 Systemic sclerosis and scleroderma. Documented as described in 14.00B3, with:

A. One of the following:

Social Security Administration

1. Muscle involvement, as described under the criteria in 14.05; or

2. Respiratory involvement, as described under the criteria in 3.00ff; or

3. Cardiovascular involvement, as described under the criteria in 4.00ff; or

4. Digestive involvement, as described under the criteria in 5.00ff; or

5. Renal involvement, as described under the criteria in 6.00ff.

or

B. Lesser involvement of two or more organs/body systems listed in paragraph A, with significant, documented, constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. At least one of the organs/body systems must be involved to at least a moderate level of severity.

or

C. Generalized scleroderma with digital contractures.

or

D. Severe Raynaud's phenomena, characterized by digital ulcerations, ischemia, or gangrene.

14.05 Polymyositis or dermatomyositis. Documented as described in 14.00B4, with:

A. Severe proximal limb-girdle (shoulder and/or pelvic) muscle weakness, as described in 14.00B4.

or

B. Less severe limb-girdle muscle weakness than in 14.05A, associated with cervical muscle weakness and one of the following to at least a moderate level of severity:

1. Impaired swallowing with dysphagia and episodes of aspiration due to cricopharyngeal weakness; or
2. Impaired respiration due to intercostal and diaphragmatic muscle weakness.

or

C. If associated with malignant tumor, as described under the criteria in 13.00ff.

or

D. If associated with generalized connective tissue disease, described under the criteria in 14.02, 14.03, 14.04, or 14.06.

14.06 Undifferentiated connective tissue disorder. Documented as described in 14.00B5, and with impairment as described under the criteria in 14.02A, 14.02B, or 14.04.

14.07 Immunoglobulin deficiency syndromes or deficiencies of cell-mediated immunity, excepting HIV infection. Associated with documented, recurrent severe infection occurring 3 or more times within a 5-month period.

14.08 Human immunodeficiency virus (HIV) infection. With documentation as described in 14.00D3 and one of the following:

A. Bacterial infections:

1. Mycobacterial infection (e.g., caused by *M. avium*-intracellulare, *M. kansasii*, or *M. tuberculosis*) at a site other than the lungs, skin, or cervical or hilar lymph nodes; or

pulmonary tuberculosis resistant to treatment; or

2. Nocardiosis; or

3. *Salmonella* bacteremia, recurrent nontyphoid; or

4. Syphilis or neurosyphilis—evaluate sequelae under the criteria for the affected body system (e.g., 2.00 Special Senses and Speech, 4.00 Cardiovascular System, 11.00 Neurological); or

5. Multiple or recurrent bacterial infection(s), including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in 1 year.

or

B. Fungal infections:

1. Aspergillosis; or

2. Candidiasis, at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs; or

3. Coccidioidomycosis, at a site other than the lungs or lymph nodes; or

4. Cryptococcosis, at a site other than the lungs (e.g., cryptococcal meningitis); or

5. Histoplasmosis, at a site other than the lungs or lymph nodes; or

6. Mucormycosis.

or

C. Protozoan or helminthic infections:

1. Cryptosporidiosis, isosporiasis, or microsporidiosis, with diarrhea lasting for 1 month or longer; or

2. Pneumocystis carinii pneumonia or extrapulmonary pneumocystis carinii infection; or

3. Strongyloidiasis, extra-intestinal; or

4. Toxoplasmosis of an organ other than the liver, spleen, or lymph nodes.

or

D. Viral infections:

1. Cytomegalovirus disease (documented as described in 14.00D4b) at a site other than the liver, spleen, or lymph nodes; or

2. Herpes simplex virus causing:
a. Mucocutaneous infection (e.g., oral, genital, perianal) lasting for 1 month or longer; or

b. Infection at a site other than the skin or mucous membranes (e.g., bronchitis, pneumonia, esophagitis, or encephalitis); or

c. Disseminated infection; or

3. Herpes zoster, either disseminated or with multidermatomal eruptions that are resistant to treatment; or

4. Progressive multifocal leukoencephalopathy; or

5. Hepatitis, as described under the criteria in 5.05.

or

E. Malignant neoplasms:

1. Carcinoma of the cervix, invasive, FIGO stage II and beyond; or

2. Kaposi's sarcoma with:
 a. Extensive oral lesions; or
 b. Involvement of the gastrointestinal tract, lungs, or other visceral organs; or
 c. Involvement of the skin or mucous membranes, as described under the criteria in 14.06F; or
 3. Lymphoma (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkins lymphoma, Hodgkin's disease); or
 4. Squamous cell carcinoma of the anus.

or

F. Conditions of the skin or mucous membranes (other than described in B2, D2, or D3, above) with extensive fungating or ulcerating lesions not responding to treatment (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease), or evaluate under the criteria in 8.00ff.

or

- G. Hematologic abnormalities:
 1. Anemia, as described under the criteria in 7.02; or
 2. Granulocytopenia, as described under the criteria in 7.15; or
 3. Thrombocytopenia, as described under the criteria in 7.06.

or

- H. Neurological abnormalities:
 1. HIV encephalopathy, characterized by cognitive or motor dysfunction that limits function and progresses; or
 2. Other neurological manifestations of HIV infection (e.g., peripheral neuropathy) as described under the criteria in 11.00ff.

or

- I. HIV wasting syndrome, characterized by involuntary weight loss of 10 percent or more of baseline (or other significant involuntary weight loss, as described in 14.00D2) and, in the absence of a concurrent illness that could explain the findings, either:
 1. Chronic diarrhea with two or more loose stools daily lasting for 1 month or longer; or
 2. Chronic weakness and documented fever greater than 38° C (100.4° F) for the majority of 1 month or longer.

or

- J. Diarrhea, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding.

or

- K. Cardiomyopathy, as described under the criteria in 4.00ff or 11.04.

or

- L. Nephropathy, as described under the criteria in 6.00ff.

or

M. One or more of the following infections (other than described in A-L, above), resistant to treatment or requiring hospitalization or intravenous treatment 3 or more times in 1 year (or evaluate sequelae under the criteria for the affected body system).

1. Sepsis; or
2. Meningitis; or
3. Pneumonia; or
4. Septic arthritis; or
5. Endocarditis; or
6. Radiographically documented sinusitis.

or

N. Repeated (as defined in 14.00D8) manifestations of HIV infection (including those listed in 14.08A-M, but without the requisite findings, e.g., carcinoma of the cervix not meeting the criteria in 14.08E, diarrhea not meeting the criteria in 14.08J, or other manifestations, e.g., oral hairy leukoplakia, myositis) resulting in significant, documented symptoms or signs (e.g., fatigue, fever, malaise, weight loss, pain, night sweats) and one of the following at the marked level (as defined in 14.00D8):

1. Restriction of activities of daily living; or
2. Difficulties in maintaining social functioning; or
3. Difficulties in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

Part B

Medical criteria for the evaluation of impairments of children under age 18 (where criteria in Part A do not give appropriate consideration to the particular disease process in childhood).

Sec.

- 100.00 Growth Impairment.
- 101.00 Musculoskeletal System.
- 102.00 Special Senses and Speech.
- 103.00 Respiratory System.
- 104.00 Cardiovascular System.
- 105.00 Digestive System.
- 106.00 Genito-Urinary System.
- 107.00 Hemic and Lymphatic System.
- 108.00 [Reserved]
- 109.00 Endocrine System.
- 110.00 Multiple Body Systems.
- 111.00 Neurological.
- 112.00 Mental and Emotional Disorders.
- 113.00 Neoplastic Diseases, Malignant.
- 114.00 Immune System.

100.00 GROWTH IMPAIRMENT

A. Impairment of growth may be disabling in itself or it may be an indicator of the severity of the impairment due to a specific disease process.

Determinations of growth impairment should be based upon the comparison of current height with at least three previous determinations, including length at birth, if available. Heights (or lengths) should be plotted

on a standard growth chart, such as derived from the National Center for Health Statistics: NCHS Growth Charts. Height should be measured without shoes. Body weight corresponding to the ages represented by the heights should be furnished. The adult heights of the child's natural parents and the heights and ages of siblings should also be furnished. This will provide a basis upon which to identify those children whose short stature represents a familial characteristic rather than a result of disease. This is particularly true for adjudication under 100.02B.

B. Bone age determinations should include a full descriptive report of roentgenograms specifically obtained to determine bone age and must cite the standardization method used. Where roentgenograms must be obtained currently as a basis for adjudication under 100.03, views of the left hand and wrist should be ordered. In addition, roentgenograms of the knee and ankle should be obtained when cessation of growth is being evaluated in an older child at, or past, puberty.

C. The criteria in this section are applicable until closure of the major epiphyses. The cessation of significant increase in height at that point would prevent the application of these criteria.

100.01 Category of Impairments, Growth
 100.02 Growth impairment, considered to be related to an additional specific medically determinable impairment, and one of the following:

A. Fall of greater than 15 percentiles in height which is sustained; or

B. Fall to, or persistence of, height below the third percentile.

100.03 Growth impairment, not identified as being related to an additional, specific medically determinable impairment. With:

A. Fall of greater than 25 percentiles in height which is sustained; and

B. Bone age greater than two standard deviations (2 SD) below the mean for chronological age (see 100.00B).

101.00 MUSCULOSKELETAL SYSTEM

A. Rheumatoid arthritis. Documentation of the diagnosis of juvenile rheumatoid arthritis should be made according to an established protocol, such as that published by the Arthritis Foundation, *Bulletin on the Rheumatic Diseases*, Vol. 23, 1972-1973 Series, p 712. Inflammatory signs include persistent pain, tenderness, erythema, swelling, and increased local temperature of a joint.

B. The measurements of joint motion are based on the technique for measurements described in the "Joint Method of Measuring and Recording," published by the American Academy of Orthopedic Surgeons in 1965, or "The Extremities and Back" in *Guides to the Evaluation of Permanent Impairment*, Chicago, American Medical Association, 1971, Chapter 1, pp. 1-48.

C. Degenerative arthritis may be the end stage of many skeletal diseases and conditions, such as traumatic arthritis, collagen disorders, septic arthritis, congenital dislocation of the hip, aseptic necrosis of the hip, slipped capital femoral epiphyses, skeletal dysplasias, etc.

101.01 Category of Impairments, Musculoskeletal

101.02 Juvenile rheumatoid arthritis. With:
 A. Persistence or recurrence of joint inflammation despite three months of medical

listings for kids

101.02 Juvenile rheumatoid arthritis. With:
 A. Persistence or recurrence of joint inflammation despite three months of medical

distance despite orthotic or prosthetic devices; or

B. Ambulation is possible only with obligatory bilateral upper limb assistance (e.g., with walker, crutches); or

C. Inability to perform age-related personal self-care activities involving feeding, dressing, and personal hygiene.

101.05 Disorders of the spine.

A. Fracture of vertebra with cord involvement (substantiated by appropriate sensory and motor loss); or

B. Scoliosis (congenital idiopathic or neuromyopathic). With:

1. Major spinal curve measuring 60 degrees or greater; or

2. Spinal fusion of six or more levels. Consider under a disability for one year from the time of surgery; thereafter evaluate the residual impairment; or

3. FEV (vital capacity) of 50 percent or less of predicted normal values for the individual's measured (actual) height; or

C. Kyphosis or lordosis measuring 90 degrees or greater.

101.08 Chronic osteomyelitis with persistence or recurrence of inflammatory signs or drainage for at least 6 months despite prescribed therapy and consistent radiographic findings.

102.00 SPECIAL SENSES AND SPEECH

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

2. Kaposi's sarcoma with:
- Extensive oral lesions; or
 - Involvement of the gastrointestinal tract, lungs, or other visceral organs; or
 - Involvement of the skin or mucous membranes, as described under the criteria in 14.08F; or
 - Lymphoma (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkins lymphoma, Hodgkin's disease); or
 - Squamous cell carcinoma of the anus.

or

F. Conditions of the skin or mucous membranes (other than described in B2, D2, or D3, above) with extensive fungating or ulcerating lesions not responding to treatment (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease), or evaluate under the criteria in 8.00ff.

or

- G. Hematologic abnormalities:
- Anemia, as described under the criteria in 7.02; or
 - Granulocytopenia, as described under the criteria in 7.15; or
 - Thrombocytopenia, as described under the criteria in 7.06.

or

- H. Neurological abnormalities:
- HIV encephalopathy, characterized by cognitive or motor dysfunction that limits function and progresses; or
 - Other neurological manifestations of HIV infection (e.g., peripheral neuropathy) as described under the criteria in 11.00ff.

or

- I. HIV wasting syndrome, characterized by involuntary weight loss of 10 percent or more of baseline (or other significant involuntary weight loss, as described in 14.00D2) and, in the absence of a concurrent illness that could explain the findings, either:
- Chronic diarrhea with two or more loose stools daily lasting for 1 month or longer; or
 - Chronic weakness and documented fever greater than 38° C (100.4° F) for the majority of 1 month or longer.

or

- J. Diarrhea, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding.

or

- K. Cardiomyopathy, as described under the criteria in 4.00ff or 11.04.

or

- L. Nephropathy, as described under the criteria in 6.00ff.

or

M. One or more of the following infections (other than described in A-L, above), resistant to treatment or requiring hospitalization or intravenous treatment 3 or more times in 1 year (or evaluate sequelae under the criteria for the affected body system).

- Sepsis; or
- Meningitis; or
- Pneumonia; or
- Septic arthritis; or
- Endocarditis; or
- Radiographically documented sinusitis.

or

N. Repeated (as defined in 14.00D8) manifestations of HIV infection (including those listed in 14.08A-M, but without the requisite findings, e.g., carcinoma of the cervix not meeting the criteria in 14.08E, diarrhea not meeting the criteria in 14.08J, or other manifestations, e.g., oral hairy leukoplakia, myositis) resulting in significant, documented symptoms or signs (e.g., fatigue, fever, malaise, weight loss, pain, night sweats) and one of the following at the marked level (as defined in 14.00D8):

- Restriction of activities of daily living; or
- Difficulties in maintaining social functioning; or
- Difficulties in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

Part B

Medical criteria for the evaluation of impairments of children under age 18 (where criteria in Part A do not give appropriate consideration to the particular disease process in childhood).

- Sec.
- 100.00 Growth Impairment.
 - 101.00 Musculoskeletal System.
 - 102.00 Special Senses and Speech.
 - 103.00 Respiratory System.
 - 104.00 Cardiovascular System.
 - 105.00 Digestive System.
 - 106.00 Genito-Urinary System.
 - 107.00 Hemic and Lymphatic System.
 - 108.00 [Reserved]
 - 109.00 Endocrine System.
 - 110.00 Multiple Body Systems.
 - 111.00 Neurological.
 - 112.00 Mental and Emotional Disorders.
 - 113.00 Neoplastic Diseases, Malignant.
 - 114.00 Immune System.

100.00 GROWTH IMPAIRMENT

A. *Impairment of growth* may be disabling in itself or it may be an indicator of the severity of the impairment due to a specific disease process.

Determinations of growth impairment should be based upon the comparison of current height with at least three previous determinations, including length at birth, if available. Heights (or lengths) should be plotted

Social Security Administration

on a standard growth chart, such as derived from the National Center for Health Statistics: NCHS Growth Charts. Height should be measured without shoes. Body weight corresponding to the ages represented by the heights should be furnished. The adult heights of the child's natural parents and the heights and ages of siblings should also be furnished. This will provide a basis upon which to identify those children whose short stature represents a familial characteristic rather than a result of disease. This is particularly true for adjudication under 100.02B.

B. *Bone age determinations* should include a full descriptive report of roentgenograms specifically obtained to determine bone age and must cite the standardization method used. Where roentgenograms must be obtained currently as a basis for adjudication under 100.03, views of the left hand and wrist should be ordered. In addition, roentgenograms of the knee and ankle should be obtained when cessation of growth is being evaluated in an older child at, or past, puberty.

C. The criteria in this section are applicable until closure of the major epiphyses. The cessation of significant increase in height at that point would prevent the application of these criteria.

100.01 Category of Impairments, Growth
100.02 *Growth impairment*, considered to be related to an additional specific medically determinable impairment, and one of the following:

- Fall of greater than 15 percentiles in height which is sustained; or
- Fall to, or persistence of, height below the third percentile.

100.03 *Growth impairment*, not identified as being related to an additional, specific medically determinable impairment. With:

- Fall of greater than 25 percentiles in height which is sustained; and
- Bone age greater than two standard deviations (2 SD) below the mean for chronological age (see 100.00B).

101.00 MUSCULOSKELETAL SYSTEM

A. *Rheumatoid arthritis*. Documentation of the diagnosis of juvenile rheumatoid arthritis should be made according to an established protocol, such as that published by the Arthritis Foundation, *Bulletin on the Rheumatic Diseases*. Vol. 23, 1972-1973 Series, p 712. Inflammatory signs include persistent pain, tenderness, erythema, swelling, and increased local temperature of a joint.

B. *The measurements of joint motion* are based on the technique for measurements described in the "Joint Method of Measuring and Recording," published by the American Academy of Orthopedic Surgeons in 1965, or "The Extremities and Back" in *Guides to the Evaluation of Permanent Impairment*, Chicago, American Medical Association, 1971, Chapter 1, pp. 1-48.

C. *Degenerative arthritis* may be the end stage of many skeletal diseases and conditions, such as traumatic arthritis, collagen disorders septic arthritis, congenital dislocation of the hip, aseptic necrosis of the hip, slipped capital femoral epiphyses, skeletal dysplasias, etc.

101.01 Category of Impairments, Musculoskeletal

101.02 *Juvenile rheumatoid arthritis*. With:

A. Persistence or recurrence of joint inflammation despite three months of medical treatment and one of the following:

- Limitation of motion of two major joints of 50 percent or greater; or
- Fixed deformity of two major weight-bearing joints of 30 degrees or more; or
- Radiographic changes of joint narrowing, erosion, or subluxation; or
- Persistent or recurrent systemic involvement such as iridocyclitis or pericarditis; or

B. Steroid dependence.

101.03 *Deficit of musculoskeletal function* due to deformity or musculoskeletal disease and one of the following:

A. Walking is markedly reduced in speed or distance despite orthotic or prosthetic devices; or

B. Ambulation is possible only with obligatory bilateral upper limb assistance (e.g., with walker, crutches); or

C. Inability to perform age-related personal self-care activities involving feeding, dressing, and personal hygiene.

101.05 *Disorders of the spine*.

A. Fracture of vertebra with cord involvement (substantiated by appropriate sensory and motor loss); or

B. Scoliosis (congenital idiopathic or neuromuscular). With:

- Major spinal curve measuring 60 degrees or greater; or

2. Spinal fusion of six or more levels. Consider under a disability for one year from the time of surgery; thereafter evaluate the residual impairment; or

3. FEV (vital capacity) of 50 percent or less of predicted normal values for the individual's measured (actual) height; or

C. Kyphosis or lordosis measuring 90 degrees or greater.

101.08 *Chronic osteomyelitis* with persistence or recurrence of inflammatory signs or drainage for at least 6 months despite prescribed therapy and consistent radiographic findings.

102.00 SPECIAL SENSES AND SPEECH

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

used for determining the central visual acuity for distance.

The *accommodative reflex* is generally not present in children under 6 months of age. In premature infants, it may not be present until 6 months plus the number of months the child is premature. Therefore absence of accommodative reflex will be considered as indicating a visual impairment only in children above this age (6 months).

Documentation of a visual disorder must include description of the ocular pathology.

B. *Hearing impairments in children.* The criteria for hearing impairments in children take into account that a lesser impairment in hearing which occurs at an early age may result in a severe speech and language disorder.

Improvement by a hearing aid, as predicted by the testing procedure, must be demonstrated to be feasible in that child, since younger children may be unable to use a hearing aid effectively.

The type of audiometric testing performed must be described and a copy of the results must be included. The pure tone air conduction hearing levels in 102.08 are based on American National Standard Institute Specifications for Audiometers, S3.6-1969 (ANSI-1969). The report should indicate the specifications used to calibrate the audiometer.

The finding of a severe impairment will be based on the average hearing levels at 500, 1000, 2000, and 3000 Hertz (Hz) in the better ear, and on speech discrimination, as specified in § 102.08.

102.01 Category of Impairments, Special Sense Organs

102.02 *Impairments of central visual acuity.*

A. Remaining vision in the better eye after best correction is 20/200 or less; or

B. For children below 3 years of age at time of adjudication:

1. Absence of accommodative reflex (see 102.00A for exclusion of children under 6 months of age); or

2. Retrolental fibroplasia with macular scarring or neovascularization; or

3. Bilateral congenital cataracts with visualization of retinal red reflex only or when associated with other ocular pathology.

102.08 *Hearing impairments.*

A. For children below 5 years of age at time of adjudication, inability to hear air conduction thresholds at an average of 40 decibels (db) hearing level or greater in the better ear; or

B. For children 5 years of age and above at time of adjudication:

1. Inability to hear air conduction thresholds at an average of 70 decibels (db) or greater in the better ear; or

2. Speech discrimination scores at 40 percent or less in the better ear; or

3. Inability to hear air conduction thresholds at an average of 40 decibels (db) or greater in the better ear, and a speech and

language disorder which significantly affects the clarity and content of the speech and is attributable to the hearing impairment.

103.00 RESPIRATORY SYSTEM

A. *Introduction.* The listings in this section describe impairments resulting from respiratory disorder based on symptoms, physical signs, laboratory test abnormalities, and response to a regimen of treatment prescribed by a treating source. Respiratory disorders, along with any associated impairment(s) must be established by medical evidence. Evidence must be provided in sufficient detail to permit an independent reviewer to evaluate the severity of the impairment. Reasonable efforts should be made to ensure evaluation by a program physician specializing in childhood respiratory impairments or a qualified pediatrician.

Many children, especially those who have listing-level impairments, will have received the benefit of medically prescribed treatment. Whenever there is such evidence, the longitudinal clinical record must include a description of the treatment prescribed by the treating source and response, in addition to information about the nature and severity of the impairment. It is important to document any prescribed treatment and response because this medical management may have improved the child's functional status. The longitudinal record should provide information regarding functional recovery, if any.

Some children will not have received ongoing treatment or have an ongoing relationship with the medical community, despite the existence of a severe impairment(s). A child who does not receive treatment may or may not be able to show an impairment that meets the criteria of these listings. Even if a child does not show that his or her impairment meets the criteria of these listings, the child may have an impairment(s) equivalent in severity to one of the listed impairments or be disabled because of a substantial reduction in the ability to function independently, appropriately, and effectively in an age-appropriate manner. Unless the claim can be decided favorably on the basis of the current evidence, a longitudinal record is still important because it will provide information about such things as the ongoing medical severity of the impairment, the level of the child's functioning, and the frequency, severity, and duration of symptoms. Also, the asthma listing specifically includes a requirement for continuing signs and symptoms despite a regimen of prescribed treatment.

Evaluation should include consideration of adverse effects of respiratory impairment in all relevant body systems, and especially on the child's growth and development or mental functioning, as described under the growth impairment (100.00), neurological (111.00), and mental disorders (112.00) listings.

It must be remembered that these listings are only examples of common respiratory disorders that are severe enough to prevent a child from functioning independently, appropriately, and effectively in an age-appropriate manner. When a child has a medically determinable impairment that is not listed, an impairment which does not meet a listing, or a combination of impairments no one of which meets a listing, we may make an equivalence determination on medical or functional grounds. Also, with respect to children claiming SSI benefits under title XVI of the Act who have an impairment(s) with a level of severity which does not meet or equal (medically or functionally) the criteria of the listings, we will determine whether the impairment(s) is of comparable severity to one that would disable an adult. In these cases, we will perform an individualized functional assessment to determine whether the child is disabled.

B. *Documentation of Pulmonary Function Testing.* The results of spirometry that are used for adjudication, under the 103.02 A and B, 103.03, and 103.04 of these listings should be expressed in liters (L), body temperature and pressure saturated with water vapor (BTPS). The reported one-second forced expiratory volume (FEV₁) and forced vital capacity (FVC) should represent the largest of at least three satisfactory forced expiratory maneuvers. Two of the satisfactory spirometry results should be reproducible for both pre-bronchodilator tests and, if indicated, post-bronchodilator tests. A value is considered reproducible if it does not differ from the largest value by more than 5 percent or 0.1 L, whichever is greater. The highest values of the FEV₁ and FVC, whether from the same or different tracings, should be used to assess the severity of the respiratory impairment. Peak flow should be achieved early in expiration, and the spirogram should have a smooth contour with gradually decreasing flow throughout expiration. The zero time for measurement of the FEV₁ and FVC, if not distinct, should be derived by linear back-extrapolation of peak flow to zero volume. A spirogram is satisfactory for measurement of the FEV₁ if the expiratory volume at the back-extrapolated zero time is less than 5 percent of the FVC or 0.1 L, whichever is greater. The spirogram is satisfactory for measurement of the FVC if maximal expiratory effort continues for at least 6 seconds, or if there is a plateau in the volume-time curve with no detectable change in expired volume (VE) during the last 2 seconds of maximal expiratory effort.

Spirometry should be repeated after administration of an aerosolized bronchodilator under supervision of the testing personnel if the pre-bronchodilator FEV₁ value is less than the appropriate reference value in table I or III, as appropriate. If a bronchodilator is not administered, the reason

should be clearly stated in the report. Pulmonary function studies should not be performed unless the clinical status is stable (e.g., the child is not having an asthmatic attack or suffering from an acute respiratory infection or other chronic illness). Wheezing is common in asthma, chronic bronchitis, or chronic obstructive pulmonary disease and does not preclude testing. Pulmonary function studies performed to assess airflow obstruction without testing after bronchodilators cannot be used to assess levels of impairment in the range that prevents a child from performing age-appropriate activities, unless the use of bronchodilators is contraindicated. Post-bronchodilator testing should be performed 10 minutes after bronchodilator administration. The dose and name of the bronchodilator administered should be specified. The values in 103.02 and 103.04 must only be used as criteria for the level of ventilatory impairment that exists during the child's most stable state of health (i.e., any period in time except during or shortly after an exacerbation).

The appropriately labeled spirometric tracing, showing the child's name, date of testing, distance per second on the abscissa and distance per liter (L) on the ordinate, must be incorporated into the file. The manufacturer and model number of the device used to measure and record the spirogram should be stated. The testing device must accurately measure both time and volume, the latter to within 1 percent of a 3 L calibrating volume. If the spirogram was generated by any means other than direct pen linkage to a mechanical displacement-type spirometer, the spirometric tracing must show a recorded calibration of volume units using a mechanical volume input such as a 3 L syringe.

If the spirometer directly measures flow, and volume is derived by electronic integration, the linearity of the device must be documented by recording volume calibrations at three different flow rates of approximately 30 L/min (3 L/sec), 60 L/min (3 L/sec), and 180 L/min (3 L/sec). The volume calibrations should agree to within 1 percent of a 3 L calibrating volume. The proximity of the flow sensor to the child should be noted, and it should be stated whether or not a BTPS correction factor was used for the calibration recordings and for the child's actual spirometry.

The spirogram must be recorded at a speed of at least 20 mm/sec and the recording device must provide a volume excursion of at least 10 mm/L. If reproductions of the original spirometric tracings are submitted, they must be legible and have a time scale of at least 20 mm/sec and a volume scale of at least 10 mm/L to permit independent measurements. Calculation of FEV₁ from a flow volume tracing is not acceptable, i.e., the

spirogram and calibrations must be presented in a volume-time format at a speed of at least 20 mm/sec and a volume excursion of at least 10 mm/L to permit independent evaluation.

A statement should be made in the pulmonary function test report of the child's ability to understand directions, as well as his or her efforts and cooperation in performing the pulmonary function tests.

Purchase of a pulmonary function test is appropriate only when the child is capable of performing reproducible forced expiratory maneuvers. This capability usually occurs around age 6. Purchase of a pulmonary function test may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided.

The pulmonary function tables in 103.02 and 103.04 are based on measurement of standing height without shoes. If a child has marked spinal deformities (e.g., kyphoscoliosis), the measured span between the fingertips with the upper extremities abducted 90 degrees should be substituted for height when this measurement is greater than the standing height without shoes.

C. Documentation of chronic impairment of gas exchange.

1. Arterial blood gas studies (ABGS). An ABGS performed at rest (while breathing room air, awake and sitting or standing) should be analyzed in a laboratory certified by a State or Federal agency. If the laboratory is not certified, it must submit evidence of participation in a national proficiency testing program as well as acceptable quality control at the time of testing. The report should include the altitude of the facility and the barometric pressure on the date of analysis.

Purchase of resting ABGS may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided. Before purchasing resting ABGS, a program physician, preferably one experienced in the care of children with pulmonary disease, must review the clinical and laboratory data short of this procedure, including spirometry, to determine whether obtaining the test would present a significant risk to the child.

2. Oximetry. Pulse oximetry may be substituted for arterial blood gases in children under 12 years of age. The oximetry unit should employ the basic technology of spectrophotometric plethysmography as described in Taylor, M.B., and Whitwain, J.G., "Current Status of Pulse Oximetry," "Anesthesia," Vol. 41, No. 9, pp. 943-949, 1986. The unit should provide a visual display of the pulse signal and the corresponding oxygen saturation. A hard copy of the readings (heart rate and saturation) should be provided. Readings should be obtained for a

minimum of 5 minutes. The written report should describe patient activity during the recording, i.e., sleep, feeding, or exercise. Correlation between the actual heart rate determined by a trained observer and that displayed by the oximeter should be provided. A statement should be made in the report of the child's effort and cooperation during the test.

Purchase of oximetry may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided.

D. Cystic fibrosis is a disorder that affects either the respiratory or digestive body systems or both and may impact on a child's growth and development. It is responsible for a wide and variable spectrum of clinical manifestations and complications. Confirmation of the diagnosis is based upon an elevated sweat sodium concentration or chloride concentration accompanied by one or more of the following: the presence of chronic obstructive pulmonary disease, insufficiency of exocrine pancreatic function, meconium ileus, or a positive family history. The quantitative pilocarpine iontophoresis procedure for collection of sweat content must be utilized. Two methods are acceptable: the "Procedure for the Quantitative Iontophoretic Sweat Test for Cystic Fibrosis," published by the Cystic Fibrosis Foundation and contained in, "A Test for Concentration of Electrolytes in Sweat in Cystic Fibrosis of the Pancreas Utilizing Pilocarpine Iontophoresis," Gibson, I.E., and Cooke, R.E., "Pediatrics," Vol 23: 545, 1959; or the "Wescor Macroduct System." To establish the diagnosis of cystic fibrosis, the sweat sodium or chloride content must be analyzed quantitatively using an acceptable laboratory technique. Another diagnostic test is the "CF gene mutation analysis" for homozygosity of the cystic fibrosis gene. The pulmonary manifestations of this disorder should be evaluated under 103.04. The nonpulmonary aspects of cystic fibrosis should be evaluated under the listings for the digestive system (105.00) or growth impairments (100.00). Because cystic fibrosis may involve the respiratory and digestive body systems, as well as impact on a child's growth and development, the combined effects of this involvement must be considered in case adjudication.

E. Bronchopulmonary dysplasia (BPD). Bronchopulmonary dysplasia is a form of chronic obstructive pulmonary disease that arises as a consequence of acute lung injury in the newborn period and treatment of hyaline membrane disease, meconium aspiration, neonatal pneumonia and apnea of prematurity. The diagnosis is established by the requirement for continuous or nocturnal supplemental oxygen for more than 30 days,

in association with characteristic radiographic changes and clinical signs of respiratory dysfunction, including retractions, rales, wheezing, and tachypnea.

103.01 Category of Impairments, Respiratory System

103.02 Chronic pulmonary insufficiency. With:

A. Chronic obstructive pulmonary disease, due to any cause, with the FEV₁ equal to or less than the value specified in Table I corresponding to the child's height without shoes. (In cases of marked spinal deformity, see 103.00B.);

TABLE I

Height without shoes (centimeters)	Height without shoes (inches)	FEV ₁ equal to or less than (L, BTPS)
119 or less	46 or less	0.65
120-129	47-50	0.75
130-139	51-54	0.95
140-149	55-58	1.15
150-159	59-62	1.35
160-164	63-64	1.45
165-169	65-66	1.55
170 or more	67 or more	1.65

Or

B. Chronic restrictive ventilatory disease, due to any cause, with the FVC equal to or less than the value specified in table II corresponding to the child's height without shoes. (In cases of marked spinal deformity, see 103.00B.);

TABLE II

Height without shoes (centimeters)	Height without shoes (inches)	FVC equal to or less than (L, BTPS)
119 or less	46 or less	0.65
120-129	47-50	0.85
130-139	51-54	1.05
140-149	55-58	1.25
150-159	59-62	1.45
160-164	63-64	1.65
165-169	65-66	1.75
170 or more	67 or more	2.05

Or

C Frequent need for:

1. Mechanical ventilation; or
2. Nocturnal supplemental oxygen as required by persistent or recurrent episodes of hypoxemia;

Or

D. The presence of a tracheostomy in a child under 3 years of age;

Or

E. Bronchopulmonary dysplasia characterized by two of the following:

1. Prolonged expirations; or

2. Intermittent wheezing or increased respiratory effort as evidenced by retractions, flaring and tachypnea; or

3. Hyperinflation and scarring on a chest radiograph or other appropriate imaging techniques; or

4. Bronchodilator or diuretic dependency; or

5. A frequent requirement for nocturnal supplemental oxygen; or

6. Weight disturbance with:

a. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall of 15 percentiles from established growth curve (on standard growth charts) which persists for 2 months or longer; or

b. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall to below the third percentile from established growth curve (on standard growth charts) which persists for 2 months or longer;

Or

F. Two required hospital admissions (each longer than 24 hours) within a 6-month period for recurrent lower respiratory tract infections or acute respiratory distress associated with:

1. Chronic wheezing or chronic respiratory distress; or

2. Weight disturbance with:

a. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall of 15 percentiles from established growth curve (on standard growth charts) which persists for 2 months or longer; or

b. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall to below the third percentile from established growth curve (on standard growth charts) which persists for 2 months or longer;

Or

G. Chronic hypoventilation (PaCO₂ greater than 45 mm Hg) or chronic cor pulmonale as described under the appropriate criteria in 104.02;

Or

H. Growth impairment as described under the criteria in 100.00.

103.03 Asthma. With:

A. FEV₁ equal to or less than the value specified in Table I of 103.02A;

Or

B. Attacks (as defined in 3.00C), in spite of prescribed treatment and requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each inpatient hospitalization for longer than 24 hours for control of asthma counts as two attacks, and an evaluation period of at

least 12 consecutive months must be used to determine the frequency of attacks;

Or

C. Persistent low-grade wheezing between acute attacks or absence of extended symptom-free periods requiring daytime and nocturnal use of sympathomimetic bronchodilators with one of the following:

1. Persistent prolonged expiration with radiographic or other appropriate imaging techniques evidence of pulmonary hyperinflation or peribronchial disease; or
2. Short courses of corticosteroids that average more than 5 days per month for at least 3 months during a 12-month period;

Or

D. Growth impairment as described under the criteria in 100.00.

103.04 Cystic fibrosis. With:

A. An FEV₁ equal to or less than the appropriate value specified in Table III corresponding to the child's height without shoes. (In cases of marked spinal deformity, see 103.00B.);

Or

B. For children in whom pulmonary function testing cannot be performed, the presence of two of the following:

1. History of dyspnea on exertion or accumulation of secretions as manifested by repetitive coughing or cyanosis; or
2. Persistent bilateral rales and rhonchi or substantial reduction of breath sounds related to mucous plugging of the trachea or bronchi; or
3. Radiographic evidence of extensive disease, such as thickening of the proximal bronchial airways or persistence of bilateral peribronchial infiltrates;

Or

C. Persistent pulmonary infection accompanied by superimposed, recurrent, symptomatic episodes of increased bacterial infection occurring at least once every 6 months and requiring intravenous or nebulization antimicrobial treatment;

Or

D. Episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum) or respiratory failure (documented according to 3.00C), requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each inpatient hospitalization for longer than 24 hours for treatment counts as two episodes, and an evaluation period of at least 12 consecutive months must be used to determine the frequency of episodes;

Or

E. Growth impairment as described under the criteria in 100.00.

TABLE III

[Applicable only for evaluation under 103.04A—cystic fibrosis]

Height without shoes (centimeters)	Height without shoes (inches)	FEV ₁ equal to or less (L BTPS)
119 or less	46 or less	0.75
120-129	47-50	0.85
130-139	51-54	1.05
140-149	55-58	1.35
150-159	59-62	1.55
160-164	63-64	1.85
165-169	65-66	2.05
170 or more	67 or more	2.25

104.00 CARDIOVASCULAR SYSTEM

A. Introduction

The listings in this section describe childhood impairments resulting from congenital or acquired cardiovascular disease based on symptoms, physical signs, laboratory test abnormalities, and response to a regimen of therapy prescribed by a treating source. A longitudinal clinical record covering a period of not less than 3 months of observations and therapy is usually necessary for the assessment of severity and expected duration unless the child is a neonate or the claim can be decided favorably on the basis of the current evidence. All relevant evidence must be considered in assessing a child's disability. Reasonable efforts should be made to ensure evaluation by a program physician specializing in childhood cardiovascular impairments or a qualified pediatrician.

Examples of congenital defects include: abnormalities of cardiac septation, such as ventricular septal defect or atrioventricular (AV) canal; abnormalities resulting in cyanotic heart disease, such as tetralogy of Fallot or transposition of the vessels; valvular defects or obstructions to ventricular outflow, including pulmonary or aortic stenosis and/or coarctation of the aorta; and major abnormalities of ventricular development, including hypoplastic left heart syndrome or pulmonary tricuspid atresia with hypoplastic right ventricle. Acquired heart disease may be due to cardiomyopathy, rheumatic heart disease, Kawasaki syndrome, or other etiologies. Recurrent arrhythmias, severe enough to cause functional impairment, may be seen with congenital or acquired heart disease or, more rarely, in children with structurally normal hearts.

Cardiovascular impairments, especially chronic heart failure and congenital heart disease, may result in impairments in other body systems including, but not limited to, growth, neurological, and mental. Therefore, evaluation should include consideration of

Social Security Administration

the adverse effects of cardiovascular impairment in all relevant body systems, and especially on the child's growth and development, or mental functioning, as described under the Growth impairment (100.00), Neurological (111.00), and Mental retardation (112.05) listings.

Many children, especially those who have listing-level impairments, will have received the benefit of medically prescribed treatment. Whenever there is evidence of such treatment, the longitudinal clinical record must include a description of the therapy prescribed by the treating source and response, in addition to information about the nature and severity of the impairment. It is important to document any prescribed therapy and response because this medical management may have improved the child's functional status. The longitudinal record should provide information regarding functional recovery, if any.

Some children will not have received ongoing treatment or have an ongoing relationship with the medical community despite the existence of a severe impairment(s). Unless the claim can be decided favorably on the basis of the current evidence, a longitudinal record is still important because it will provide information about such things as the ongoing medical severity of the impairment, the level of the child's functioning, and the frequency, severity, and duration of symptoms. Also, several listings include a requirement for continuing signs and symptoms despite a regimen of prescribed treatment. Even though a child who does not receive treatment may not be able to show an impairment that meets the criteria of these listings, the child may have an impairment(s) equivalent in severity to one of the listed impairments or be disabled because of a substantial reduction in the ability to function independently, appropriately, and effectively in an age-appropriate manner.

Indeed, it must be remembered that these listings are only examples of common cardiovascular disorders that are severe enough to prevent a child from functioning independently, appropriately, and effectively in an age-appropriate manner. When a child has a medically determinable impairment that is not listed, or a combination of impairments no one of which meets a listing, we will make an equivalence determination. Also, with respect to children claiming SSI benefits under title XVI of the Act who have an impairment(s) with a level of severity which does not meet or equal the criteria of the cardiovascular listings, we will determine whether the impairment(s) is of comparable severity to one that would disable an adult. In these cases, an individualized functional assessment is crucial to the evaluation of a child's ability to function independently, appropriately, and effectively in an age-appropriate

manner when the impairment(s) is severe but the criteria of these listings are not met or equaled.

B. Documentation

Each child's file must include sufficiently detailed reports on history, physical examinations, laboratory studies, and any prescribed therapy and response to allow an independent reviewer to assess the severity and duration of the cardiovascular impairment. Data should be obtained preferably from an office or center experienced in pediatric cardiac assessment. The actual electrocardiographic tracing (or adequately marked photocopy) and echocardiogram report with a copy of relevant echocardiographic views should be included (see part A, 4.00C1).

Results of additional studies necessary to substantiate the diagnosis or to document the severity of the impairment, including two-dimensional and Doppler echocardiography, and radionuclide ventriculograms, should be obtained as appropriate according to part A, 4.00C3. Ambulatory electrocardiographic monitoring may also be obtained if necessary to document the presence or severity of an arrhythmia.

Exercise testing, though increasingly used, is still less frequently indicated in children than in adults, and can rarely be successfully performed in children under 6 years of age. It may be of value in the assessment of some arrhythmias, in the assessment of the severity of chronic heart failure, and in the assessment of recovery of function following cardiac surgery or other therapy. It will only be purchased by the Social Security Administration if the case cannot be decided based on the available evidence and, if purchased, must be performed in a specialty center for pediatric cardiology or other facility qualified to perform exercise testing for children.

Purchased exercise tests should be performed using a generally accepted protocol consistent with the prevailing state of medical knowledge and clinical practice. An exercise test should not be purchased for a child for whom the performance of the test is considered to constitute a significant risk by a program physician. See 4.00C2c.

Cardiac catheterization will not be purchased by the Social Security Administration. If the results of catheterization are otherwise available, they should be obtained.

C. Treatment and Relationship to Functional Status

In general, conclusions about the severity of a cardiovascular impairment cannot be made on the basis of type of treatment rendered or anticipated. The overall clinical and laboratory evidence, including the treatment plan(s) or results, should be persuasive that a listing-level impairment exists. The

amount of function restored and the time required for improvement after treatment (medical, surgical, or a prescribed program of progressive physical activity) vary with the nature and extent of the disorder, the type of treatment, and other factors. Depending upon the timing of this treatment in relation to the alleged onset date of disability, impairment evaluation may need to be deferred for a period of up to 3 months from the date of treatment to permit consideration of treatment effects.

Evaluation should not be deferred if the claim can be favorably decided based upon the available evidence.

The most life-threatening forms of congenital heart disease and cardiac impairments, such as those listed in 104.00D, almost always require surgical treatment within the first year of life to prevent early death. Even with surgery, these impairments are so severe that it is likely that the impairment will continue to be disabling long enough to meet the duration requirement because of significant residual impairment post-surgery, or the recovery time from surgery, or a combination of both factors. Therefore, when the impairment is one of those named in 104.00D, or is as severe as one of those impairments, the presence of a listing-level impairment can usually be found on the basis of planned or actual cardiac surgery.

A child who has undergone surgical treatment for life-threatening heart disease will be found under a disability for 12 months following the date of surgery under 104.06H (for infants with life-threatening cardiac disease) or 104.09 (for a child of any age who undergoes cardiac transplantation) because of the uncertainty during that period concerning outcome or long-term results. After 12 months, continuing disability evaluation will be based upon residual impairment, which will consider the clinical course following treatment and comparison of symptoms, signs, and laboratory findings pre-operatively and after the specified period. (See §§416.994a, 404.1594, or 416.994, as appropriate, for our rules on medical improvement and whether an individual is no longer disabled.)

D. Congenital Heart Disease

Some congenital defects usually lead to listing-level impairment in the first year of life and require surgery within the first year as a life-saving measure. Examples of impairments that in most instances will require life-saving surgery before age 1, include, but are not limited to, the following: hypoplastic left heart syndrome; critical aortic stenosis with neonatal heart failure; critical coarctation of the aorta, with or without associated anomalies; complete AV canal defects; transposition of the great arteries; tetralogy of Fallot; and pulmonary atresia with intact ventricular septum.

In addition, there are rarer defects which may lead to early mortality and that may require multiple surgical interventions or a combination of surgery and other major interventional procedures (e.g., multiple "balloon" catheter procedures). Examples of such defects include single ventricle, tricuspid atresia, and multiple ventricular septal defects.

Pulmonary vascular obstructive disease can cause cardiac impairment in young children. When a large or nonrestrictive septal defect or ductus is present, pulmonary artery mean pressures of at least 70 percent of mean systemic levels are used as a criterion of listing-level impairment. In the absence of such a defect (i.e., with primary pulmonary hypertension, or in some connective tissue disorders with cardiopulmonary involvement and pulmonary vascular destruction), listing-level impairment may be present at lower levels of pulmonary artery pressure, in the range of at least 50 percent of mean systemic levels.

E. Chronic Heart Failure

Chronic heart failure in infants and children may manifest itself by pulmonary or systemic venous congestion, including cardiomegaly, chronic dyspnea, tachypnea, orthopnea, or hepatomegaly; or symptoms of limited cardiac output, such as weakness or fatigue; or a need for cardiotonic drugs. Fatigue or exercise intolerance in an infant may be manifested by prolonged feeding time associated with signs of cardiac impairment, including excessive respiratory effort and sweating. Other manifestations of chronic heart failure during infancy may include failure to gain weight or involuntary loss of weight and repeated lower respiratory tract infections.

Cardiomegaly or ventricular dysfunction must be present and demonstrated by imaging techniques, such as two-dimensional and Doppler echocardiography. (Reference: Feigenbaum, Harvey, "Echocardiography," 4th Edition, Lea and Febiger, 1986, Appendix, pp. 621-639.) Chest x-ray (8 ft. PA film) will be considered indicative of cardiomegaly if the cardiothoracic ratio is over 60 percent at age 1 year or less, or 55 percent at more than 1 year of age.

Findings of cardiomegaly on chest x-ray must be accompanied by other evidence of chronic heart failure or ventricular dysfunction. This evidence may include clinical evidence, such as hepatomegaly, edema, or pulmonary venous congestion; or echocardiographic evidence, such as marked ventricular dilatation above established normals for age, or markedly reduced ejection fraction or shortening fraction.

Social Security Administration

F. Valvular Heart Disease

Valvular heart disease requires documentation by appropriate imaging techniques, including Doppler echocardiogram studies or cardiac catheterization if catheterization results are available from a treating source or other source of record. Listing-level impairment is usually associated with critical aortic stenosis in a newborn child, persistent heart failure, arrhythmias, or valve replacement and ongoing anticoagulant therapy. The usual time after valvular surgery for adequate assessment of the results of treatment is considered to be 3 months.

G. Rheumatic Heart Disease

The diagnosis should be made in accordance with the current revised Jones criteria for guidance in the diagnosis of rheumatic fever.

104.01 Category of Impairments, Cardiovascular System.

104.02 *Chronic heart failure.* Documented by clinical and laboratory findings as described in 104.00E, and with one of the following:

A. Persistent tachycardia at rest (see Table I);

OR

B. Persistent tachypnea at rest (see Table II), or markedly decreased exercise tolerance (see 104.00E);

OR

C. Recurrent arrhythmias, as described in 104.05;

OR

D. Growth disturbance, with:
1. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall of 15 percentiles from established growth curve (on standard growth charts) which persists for 2 months or longer; or

TABLE III—ELEVATED BLOOD PRESSURE

Age	Systolic over (mmHg)	OR	Diastolic over (mmHg)
Under 1 month	95		—
1 month through 2 yrs	112		74
3 through 5 yrs	116		78
6 through 9 yrs	122		78
10 through 12 yrs	126		82
13 through 15 yrs	136		88
16 to 18 yrs	142		92

104.05 *Recurrent arrhythmias*, such as persistent or recurrent heart block (A-V dissociation), repeated symptomatic tachyarrhythmias or bradyarrhythmias or long QT syndrome arrhythmias, not related to reversible causes such as electrolyte ab-

2. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall to below the third percentile from established growth curve (on standard growth charts) which persists for 2 months or longer; or

3. Growth impairment as described under the criteria in 100.00.

TABLE I—TACHYCARDIA AT REST

Age	Apical heart (beats per minute)
Under 1 yr	150
1 through 3 yrs	130
4 through 9 yrs	120
10 through 15 yrs	110
Over 15 yrs	100

TABLE II—TACHYPNEA AT REST

Age	Respiratory rate over (per minute)
Under 1 yr	40
1 through 5 yrs	35
6 through 9 yrs	30
Over 9 yrs	25

104.03 *Hypertensive cardiovascular disease.* With persistently elevated blood pressure equal to or greater than the 95th percentile for age (see Table III), and one of the following:

A. Impaired renal function, as described in 106.02;

OR

B. Cerebrovascular damage, as described in 111.06;

OR

C. Chronic heart failure as described in 104.02.

normalities or digitalis glycoside or antiarrhythmic drug toxicity, resulting in uncontrolled repeated episodes of cardiac syncope or near syncope and arrhythmia despite prescribed treatment, including electronic pacemaker (see 104.00A if there is no

prescribed treatment), and documented by resting or ambulatory (Holter) electrocardiography coincident with the occurrence of syncope or near syncope.

104.06 *Congenital heart disease.* With one of the following:

A. Cyanotic heart disease, with persistent, chronic hypoxemia as manifested by:

1. Hematocrit of 55 percent or greater on two or more evaluations within a 3-month period; or

2. Arterial O₂ saturation of less than 90 percent in room air, or resting PO₂ of 60 Torr or less; or

3. Hypercyanotic spells, syncope, characteristic squatting, or other incapacitating symptoms directly related to documented cyanotic heart disease; or

4. Exercise intolerance with increased hypoxemia on exertion;

OR

B. Chronic heart failure with evidence of ventricular dysfunction, as described in 104.02;

OR

C. Recurrent arrhythmias as described in 104.05;

OR

D. Secondary pulmonary vascular obstructive disease with a mean pulmonary arterial pressure elevated to at least 70 percent of the mean systemic arterial pressure;

OR

E. Congenital valvular or other stenotic defects, or valvular regurgitation, as described in 104.00F and 104.07;

OR

F. Symptomatic acyanotic heart disease, with ventricular dysfunction resulting in significant restriction of age-appropriate activities or inability to complete age-appropriate tasks (see 104.00A);

OR

G. Growth failure, as described in 100.00;

OR

H. For infants under 12 months of age at the time of filing, with life-threatening congenital heart impairment that will or has required surgical treatment in the first year of life, consider the infant to be under a disability until the attainment of age 1 or for 12 months after surgery, whichever is the later event; thereafter, evaluate impairment severity with reference to 104.02 to 104.08.

104.07 *Valvular heart disease or other stenotic defects, or valvular regurgitation,* documented by appropriate imaging techniques or cardiac catheterization.

A. Evaluate according to criteria in 104.02, 104.05, 111.06, or 111.04;

OR

B. Critical aortic stenosis in newborn.

104.08 *Cardiomyopathies,* documented by appropriate imaging techniques, including echocardiography or cardiac catheterization. If catheterization results are available from a treating source. Impairment must be asso-

ciated with an ejection fraction of 50 percent or less and significant left ventricular dilatation using standardized age-appropriate echocardiographic ventricular cavity measurements. Evaluate under the criteria in 104.02, 104.05, or 111.06.

104.09 *Cardiac transplantation.* Consider under a disability for 1 year following surgery; thereafter, evaluate residual impairment under 104.02 to 104.08.

104.13 *Chronic rheumatic fever or rheumatic heart disease.* Consider under a disability for 18 months from the established onset of impairment with one of the following:

A. Persistence of rheumatic fever activity for 6 months or more which is manifested by significant murmur(s), cardiac enlargement (see 104.00E) or ventricular dysfunction, and other abnormal laboratory findings, as for example, an elevated sedimentation rate or ECG findings;

OR

B. Evidence of chronic heart failure, as described under 104.02;

OR

C. Recurrent arrhythmias, as described under 104.05.

104.14 *Hyperlipidemia.* Documented Type II homozygous hyperlipidemia with repeated plasma cholesterol levels of 500 mg/ml or greater, with one of the following:

A. Myocardial ischemia, as described in 4.04B or 4.04C;

OR

B. Significant aortic stenosis documented by Doppler echocardiographic techniques or cardiac catheterization;

OR

C. Major disruption of normal life activities by repeated hospitalizations for plasmapheresis or other prescribed therapies, including liver transplant;

OR

D. Recurrent pancreatitis complicating hyperlipidemia.

104.15 *Kawasaki syndrome.* With one of the following:

A. Major coronary artery aneurysm;

OR

B. Chronic heart failure, as described in 104.02.

105.00 DIGESTIVE SYSTEM

A. *Disorders of the digestive system* which result in disability usually do so because of interference with nutrition and growth, multiple recurrent inflammatory lesions, or other complications of the disease. Such lesions or complications usually respond to treatment. To constitute a listed impairment, these must be shown to have persisted or be expected to persist despite prescribed therapy for a continuous period of at least 12 months.

B. *Documentation of gastrointestinal impairments* should include pertinent operative findings, radiographic studies, endoscopy,

Social Security Administration

and biopsy reports. Where a liver biopsy has been performed in chronic liver disease, documentation should include the report of the biopsy.

C. *Growth retardation and malnutrition.* When the primary disorder of the digestive tract has been documented, evaluate resultant malnutrition under the criteria described in 105.08. Evaluate resultant growth impairment under the criteria described in 100.03. Intestinal disorders, including surgical diversions and potentially correctable congenital lesions, do not represent a severe impairment if the individual is able to maintain adequate nutrition growth and development.

D. *Multiple congenital anomalies.* See related criteria, and consider as a combination of impairments.

105.01 *Category of Impairments, Digestive.*

105.03 *Esophageal obstruction, caused by atresia, stricture, or stenosis* with malnutrition as described under the criteria in 105.08.

105.05 *Chronic liver disease.* With one of the following:

A. Inoperable biliary atresia demonstrated by X-ray or surgery; or

B. Intractable ascites not attributable to other causes, with serum albumin of 3.0 gm./100 ml. or less; or

C. Esophageal varices (demonstrated by angiography, barium swallow, or endoscopy or by prior performance of a specific shunt or plication procedure); or

D. Hepatic coma, documented by findings from hospital records; or

E. Hepatic encephalopathy. Evaluate under the criteria in 112.02; or

F. Chronic active inflammation or necrosis documented by SGOT persistently more than 100 units or serum bilirubin of 2.5 mg. percent or greater.

105.07 *Chronic inflammatory bowel disease (such as ulcerative colitis, regional enteritis), as documented in 105.00.* With one of the following:

A. Intestinal manifestations or complications, such as obstruction, abscess, or fistula formation which has lasted or is expected to last 12 months; or

B. Malnutrition as described under the criteria in 105.08; or

C. Growth impairment as described under the criteria in 100.03.

105.08 *Malnutrition, due to demonstrable gastrointestinal disease causing either a fall of 15 percentiles of weight which persists or the persistence of weight which is less than the third percentile (on standard growth charts).* And one of the following:

A. Stool fat excretion per 24 hours:

1. More than 15 percent in infants less than 6 months.

2. More than 10 percent in infants 6-18 months.

3. More than 6 percent in children more than 18 months; or

B. Persistent hematocrit of 30 percent or less despite prescribed therapy; or

C. Serum carotene of 40 mcg./100 ml. or less; or

D. Serum albumin of 3.0 gm./100 ml. or less.

106.00 GENITO-URINARY SYSTEM

A. *Determination of the presence of chronic renal disease* will be based upon the following factors:

1. History, physical examination, and laboratory evidence of renal disease.

2. Indications of its progressive nature or laboratory evidence of deterioration of renal function.

B. *Renal transplant.* The amount of function restored and the time required to effect improvement depend upon various factors including adequacy of post transplant renal function, incidence of renal infection, occurrence of rejection crisis, presence of systemic complications (anemia, neuropathy, etc.) and side effects of corticosteroid or immuno-suppressive agents. A period of at least 12 months is required for the individual to reach a point of stable medical improvement.

C. Evaluate associated disorders and complications according to the appropriate body system listing.

106.01 *Category of Impairments, Genito-Urinary.*

106.02 *Chronic renal disease.* With:

A. Persistent elevation of serum creatinine to 3 mg. per deciliter (100 ml.) or greater over at least 3 months; or

B. Reduction of creatinine clearance to 30 ml. per minute (43 liters/24 hours) per 1.73 m² of body surface area over at least 3 months; or

C. Chronic renal dialysis program for irreversible renal failure; or

D. Renal transplant. Consider under a disability for 12 months following surgery; thereafter, evaluate the residual impairment (see 106.00B).

106.06 *Nephrotic syndrome, with edema* not controlled by prescribed therapy. And:

A. Serum albumin less than 2 gm./100 ml.; or

B. Proteinuria more than 2.5 gm./1.73m² day.

107.00 HEMIC AND LYMPHATIC SYSTEM

A. *Sickle cell disease.* Refers to a chronic hemolytic anemia associated with sickle cell hemoglobin, either homozygous or in combination with thalassemia or with another abnormal hemoglobin (such as C or F).

Appropriate hematologic evidence for sickle cell disease, such as hemoglobin electrophoresis must be included. Vaso-occlusive, hemolytic, or aplastic episodes

should be documented by description of severity, frequency, and duration.

Disability due to sickle cell disease may be solely the result of a severe, persistent anemia or may be due to the combination of chronic progressive or episodic manifestations in the presence of a less severe anemia.

Major visceral episodes causing disability include meningitis, osteomyelitis, pulmonary infections or infarctions, cerebrovascular accidents, congestive heart failure, genitourinary involvement, etc.

B. *Coagulation defects.* Chronic inherited coagulation disorders must be documented by appropriate laboratory evidence such as abnormal thromboplastin generation, coagulation time, or factor assay.

C. *Acute leukemia.* Initial diagnosis of acute leukemia must be based upon definitive bone marrow pathologic evidence. Recurrent disease may be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. The pathology report must be included.

The designated duration of disability implicit in the finding of a listed impairment is contained in 107.11. Following the designated time period, a documented diagnosis itself is no longer sufficient to establish a severe impairment. The severity of any remaining impairment must be evaluated on the basis of the medical evidence.

107.01 Category of Impairments, Hemic and Lymphatic.

107.03 *Hemolytic anemia (due to any cause).* Manifested by persistence of hematocrit of 26 percent or less despite prescribed therapy, and reticulocyte count of 4 percent or greater.

107.05 *Sickle cell disease.* With:

A. Recent, recurrent, severe vaso-occlusive crises (musculoskeletal, vertebral, abdominal); or

B. A major visceral complication in the 12 months prior to application; or

C. A hyperhemolytic or aplastic crisis within 12 months prior to application; or

D. Chronic, severe anemia with persistence of hematocrit of 26 percent or less; or

E. Congestive heart failure, cerebrovascular damage, or emotional disorder as described under the criteria in 104.02, 111.00ff, or 112.00ff.

107.06 *Chronic idiopathic thrombocytopenic purpura of childhood* with purpura and thrombocytopenia of 40,000 platelets/cu. mm. or less despite prescribed therapy or recurrent upon withdrawal of treatment.

107.08 *Inherited coagulation disorder.* With:

A. Repeated spontaneous or inappropriate bleeding; or

B. Hemarthrosis with joint deformity.

107.11 *Acute leukemia.* Consider under a disability:

A. For 2½ years from the time of initial diagnosis; or

B. For 2½ years from the time of recurrence of active disease.

108.00 [RESERVED]

109.00 ENDOCRINE SYSTEM

A. *Cause of disability.* Disability is caused by a disturbance in the regulation of the secretion or metabolism of one or more hormones which are not adequately controlled by therapy. Such disturbances or abnormalities usually respond to treatment. To constitute a listed impairment these must be shown to have persisted or be expected to persist despite prescribed therapy for a continuous period of at least 12 months.

B. *Growth.* Normal growth is usually a sensitive indicator of health as well as of adequate therapy in children. Impairment of growth may be disabling in itself or may be an indicator of a severe disorder involving the endocrine system or other body systems. Where involvement of other organ systems has occurred as a result of a primary endocrine disorder, these impairments should be evaluated according to the criteria under the appropriate sections.

C. *Documentation.* Description of characteristic history, physical findings, and diagnostic laboratory data must be included. Results of laboratory tests will be considered abnormal if outside the normal range or greater than two standard deviations from the mean of the testing laboratory. Reports in the file should contain the information provided by the testing laboratory as to their normal values for that test.

D. *Hyperfunction of the adrenal cortex.* Evidence of growth retardation must be documented as described in 100.00. Elevated blood or urinary free cortisol levels are not acceptable in lieu of urinary 17-hydroxycorticosteroid excretion for the diagnosis of adrenal cortical hyperfunction.

E. *Adrenal cortical insufficiency.* Documentation must include persistent low plasma cortisol or low urinary 17-hydroxycorticosteroids or 17-ketogenic steroids and evidence of unresponsiveness to ACTH stimulation.

109.01 Category of Impairments, Endocrine

109.02 *Thyroid Disorders.*

A. *Hyperthyroidism* (as documented in 109.00C). With clinical manifestations despite prescribed therapy, and one of the following:

1. Elevated serum thyroxine (T₄) and either elevated free T₄ or resin T₃ uptake; or

2. Elevated thyroid uptake of radiiodine; or

3. Elevated serum triiodothyronine (T₃).

B. *Hypothyroidism.* With one of the following, despite prescribed therapy:

1. IQ of 70 or less; or

2. Growth impairment as described under the criteria in 100.02 A and B; or

3. Precocious puberty.

Social Security Administration

109.03 *Hyperparathyroidism* (as documented in 109.00C). With:

A. Repeated elevated total or ionized serum calcium; or

B. Elevated serum parathyroid hormone.

109.04 *Hypoparathyroidism* or *Pseudohypoparathyroidism.* With:

A. Severe recurrent tetany or convulsions which are unresponsive to prescribed therapy; or

B. Growth retardation as described under criteria in 100.02 A and B.

109.05 *Diabetes insipidus, documented by pathologic hypertonic saline or water deprivation test.* And one of the following:

A. Intracranial space-occupying lesion, before or after surgery; or

B. Unresponsiveness to Pitressin; or

C. Growth retardation as described under the criteria in 100.02 A and B; or

D. Unresponsive hypothalamic thirst center, with chronic or recurrent hyponatremia; or

E. Decreased visual fields attributable to a pituitary lesion.

109.06 *Hyperfunction of the adrenal cortex (Primary or secondary).* With:

A. Elevated urinary 17-hydroxycorticosteroids (or 17-ketogenic steroids) as documented in 109.00 C and D; and

B. Unresponsiveness to low-dose dexamethasone suppression.

109.07 *Adrenal cortical insufficiency* (as documented in 109.00 C and E) with recent, recurrent episodes of circulatory collapse.

109.08 *Juvenile diabetes mellitus* (as documented in 109.00C) requiring parenteral insulin. And one of the following, despite prescribed therapy:

A. Recent, recurrent hospitalizations with acidosis; or

B. Recent, recurrent episodes of hypoglycemia; or

C. Growth retardation as described under the criteria in 100.02 A or B; or

D. Impaired renal function as described under the criteria in 106.00ff.

109.09 *Iatrogenic hypercorticotoid state.*

With chronic glucocorticoid therapy resulting in one of the following:

A. Osteoporosis; or

B. Growth retardation as described under the criteria in 100.02 A or B; or

C. Diabetes mellitus as described under the criteria in 109.08; or

D. Myopathy as described under the criteria in 111.06; or

E. Emotional disorder as described under the criteria in 112.00ff.

109.10 *Pituitary dwarfism* (with documented growth hormone deficiency). And growth impairment as described under the criteria in 100.02B.

109.11 *Adrenogenital syndrome.* With:

A. Recent, recurrent self-losing episodes despite prescribed therapy; or

B. Inadequate replacement therapy manifested by accelerated bone age and virilization; or

C. Growth impairment as described under the criteria in 100.02 A or B.

109.12 *Hypoglycemia* (as documented in 109.00C). With recent, recurrent hypoglycemic episodes producing convulsion or coma.

109.13 *Gonadal Dysgenesis* (Turner's Syndrome), chromosomally proven. Evaluate the resulting impairment under the criteria for the appropriate body system.

110.00 MULTIPLE BODY SYSTEMS

A. This section refers to those life-threatening catastrophic congenital abnormalities and other serious hereditary, congenital, or acquired disorders that usually affect two or more body systems and are expected to:

1. Result in early death or developmental attainment of less than 2 years of age as described in listing 110.08 (e.g., anencephaly or Tay-Sachs); or

2. Produce long-term, if not life-long, significant interference with age-appropriate major daily or personal care activities as described in listings 110.06 and 110.07. (Significant interference with age-appropriate activities is considered to exist where the developmental milestone age did not exceed two-thirds of the chronological age at the time of evaluation and such interference has lasted or could be expected to last at least 12 months.) See 112.00C for a discussion of developmental milestone criteria and evaluation of age-appropriate activities.

Down syndrome (except for mosaic Down syndrome, which is to be evaluated under listing 110.07) established by clinical findings, including the characteristic physical features, and laboratory evidence is considered to meet the requirement of listing 110.06 commencing at birth. Examples of disorders that should be evaluated under listing 110.07 include mosaic Down syndrome and chromosomal abnormalities other than Down syndrome, in which a pattern of multiple impairments (including mental retardation) is known to occur, phenylketonuria (PKU), fetal alcohol syndrome, and severe chronic neonatal infections such as toxoplasmosis, rubella syndrome, cytomegalic inclusion disease, and herpes encephalitis.

B. Documentation must include confirmation of a positive diagnosis by a clinical description of the usual abnormal physical findings associated with the condition and definitive laboratory tests, including chromosomal analysis, where appropriate (e.g., Down syndrome). Medical evidence that is persuasive that a positive diagnosis has been confirmed by appropriate laboratory testing, at some time prior to evaluation, is acceptable in lieu of a copy of the actual laboratory report.

C. When multiple body system manifestations do not meet one of the established criteria of one of the listings, the combined impairments must be evaluated together to determine if they are equal in severity to a listed impairment.

110.01 Category of Impairments, Multiple Body Systems

110.06 *Down syndrome (excluding mosaic Down syndrome)* established by clinical and laboratory findings, as described in 110.00B. Consider the child disabled from birth.

110.07 *Multiple body dysfunction* due to any confirmed (see 110.00B) hereditary, congenital, or acquired condition with one of the following:

A. Persistent motor dysfunction as a result of hypotonia and/or musculoskeletal weakness, postural reaction deficit, abnormal primitive reflexes, or other neurological impairment as described in 111.00C, and with significant interference with age-appropriate major daily or personal care activities, which in an infant or young child include such activities as head control, swallowing, following, reaching, grasping, turning, sitting, crawling, walking, taking solids, feeding self; or

B. Mental impairment as described under the criteria in 112.05 or 112.12; or

C. Growth impairment as described under the criteria in 100.02A or B; or

D. Significant interference with communication due to speech, hearing, or visual impairments as described under the criteria in 102.00 and 111.09; or

E. Cardiovascular impairments as described under the criteria in 104.00; or

F. Other impairments such as, but not limited to, malnutrition, hypothyroidism, or seizures should be evaluated under the criteria in 105.08, 109.02 or 111.02 and 111.03, or the criteria for the affected body system.

110.08 *Catastrophic congenital abnormalities or disease*. With:

A. A positive diagnosis (such as anencephaly, trisomy D or E, cyclopia, etc.), generally regarded as being incompatible with extrauterine life; or

B. A positive diagnosis (such as cri du chat, Tay-Sachs Disease) wherein attainment of the growth and development level of 2 years is not expected to occur.

111.00 NEUROLOGICAL

A. *Seizure disorder* must be substantiated by at least one detailed description of a typical seizure. Report of recent documentation should include an electroencephalogram and neurological examination. Sleep EEG is preferable, especially with temporal lobe seizures. Frequency of attacks and any associated phenomena should also be substantiated.

Young children may have convulsions in association with febrile illnesses. Proper use of 111.02 and 111.03 requires that a seizure dis-

order be established. Although this does not exclude consideration of seizures occurring during febrile illnesses, it does require documentation of seizures during nonfebrile periods.

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

B. *Minor motor seizures*. Classical petit mal seizures must be documented by characteristic EEG pattern, plus information as to age at onset and frequency of clinical seizures. Myoclonic seizures, whether of the typical infantile or Lennox-gastaut variety after infancy, must also be documented by the characteristic EEG pattern plus information as to age at onset and frequency of seizures.

C. *Motor dysfunction*. As described in 111.06, motor dysfunction may be due to any neurological disorder. It may be due to static or progressive conditions involving any area of the nervous system and producing any type of neurological impairment. This may include weakness, spasticity, lack of coordination, ataxia, tremor, athetosis, or sensory loss. Documentation of motor dysfunction must include neurologic findings and description of type of neurologic abnormality (e.g., spasticity, weakness), as well as a description of the child's functional impairment (i.e., what the child is unable to do because of the abnormality). Where a diagnosis has been made, evidence should be included for substantiation of the diagnosis (e.g., blood chemistries and muscle biopsy reports), wherever applicable.

D. *Impairment of communication*. The documentation should include a description of a recent comprehensive evaluation, including all areas of affective and effective communication, performed by a qualified professional.

111.01 Category of Impairment, Neurological

111.02 Major motor seizure disorder.

A. *Major motor seizures*. In a child with an established seizure disorder, the occurrence of more than one major motor seizure per month despite at least three months of prescribed treatment. With:

1. Daytime episodes (loss of consciousness and convulsive seizures); or
2. Nocturnal episodes manifesting residuals which interfere with activity during the day.

B. *Major motor seizures*. In a child with an established seizure disorder, the occurrence of at least one major motor seizure in the year prior to application despite at least three months of prescribed treatment. And one of the following:

1. IQ of 70 or less; or

Social Security Administration

2. Significant interference with communication due to speech, hearing, or visual defect; or

3. Significant emotional disorder; or

4. Where significant adverse effects of medication interfere with major daily activities.

111.03 *Minor motor seizures*. With:

Kids mental impairment listings

1. A. Fine and gross movements; or

B. Gait and station.

111.07 *Cerebral palsy*. With:

A. Motor dysfunction meeting the requirements of 111.06 or 101.03; or

B. Less severe motor dysfunction (but more than slight) and one of the following:

1. IQ of 70 or less; or
2. Seizure disorder, with at least one major motor seizure in the year prior to application; or
3. Significant interference with communication due to speech, hearing or visual defect; or
4. Significant emotional disorder.

111.08 *Meningomyelocele (and related disorders)*. With one of the following despite prescribed treatment:

A. Motor dysfunction meeting the requirements of §101.03 or §111.06; or

B. Less severe motor dysfunction (but more than slight), and:

1. Urinary or fecal incontinence when inappropriate for age; or
2. IQ of 70 or less; or
3. Four extremity involvement; or
4. Noncompensated hydrocephalus producing interference with mental or motor developmental progression.

111.09 *Communication impairment, associated with documented neurological disorder*. And one of the following:

A. Documented speech deficit which significantly affects the clarity and content of the speech; or

B. Documented comprehension deficit resulting in ineffective verbal communication for age; or

C. Impairment of hearing as described under the criteria in 102.08.

112.00 MENTAL DISORDERS

A. *Introduction*: The structure of the mental disorders listings for children under age 18 parallels the structure for the mental disorders listings for adults but is modified to reflect the presentation of mental disorders in children. The listings for mental disorders in children are arranged in 11 diagnostic categories: Organic mental disorders (112.02); schizophrenic, delusional (paranoid), schizoaffective, and other psychotic disorders (112.03); mood disorders (112.04); mental retardation (112.05); anxiety disorders (112.06); somatoform, eating, and tic disorders (112.07); personality disorders (112.08); psychoactive substance dependence disorders (112.09); autistic disorder and other pervasive developmental disorders (112.10); attention deficit hyperactivity disorder (112.11); and developmental and emotional disorders of newborn and younger infants (112.12).

There are significant differences between the listings for adults and the listings for children. There are disorders found in children that have no real analogy in adults; hence, the differences in the diagnostic categories for children. The presentation of mental disorders in children, particularly the very young child, may be subtle and of a character different from the signs and symptoms found in adults. For example, findings such as separation anxiety, failure to mold or bond with the parents, or withdrawal may serve as findings comparable to findings that mark mental disorders in adults. The activities appropriate to children, such as learning, growing, playing, maturing, and school adjustment, are also different from the activities appropriate to the adult and vary widely in the different childhood stages.

Each listing begins with an introductory statement that describes the disorder or disorders addressed by the listing. This is followed (except in listings 112.05 and 112.12) by medical findings (paragraph A criteria), which, if satisfied, lead to an assessment of impairment-related functional limitations (paragraph B criteria). An individual will be found to have a listed impairment when the criteria of both paragraphs A and B of the listed impairment are satisfied.

The purpose of the criteria in paragraph A is to substantiate medically the presence of a particular mental disorder. Specific symptoms and signs under any of the listings 112.02 through 112.12 cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) indicated by the medical findings.

C. When multiple body system manifestations do not meet one of the established criteria of one of the listings, the combined impairments must be evaluated together to determine if they are equal in severity to a listed impairment.

110.01 Category of Impairments, Multiple Body Systems

110.06 Down syndrome (excluding mosaic Down syndrome) established by clinical and laboratory findings, as described in 110.00B. Consider the child disabled from birth.

110.07 Multiple body dysfunction due to any confirmed (see 110.00B) hereditary, congenital, or acquired condition with one of the following:

A. Persistent motor dysfunction as a result of hypotonia and/or musculoskeletal weakness, postural reaction deficit, abnormal primitive reflexes, or other neurological impairment as described in 111.00C, and with significant interference with age-appropriate major daily or personal care activities, which in an infant or young child include such activities as head control, swallowing, following, reaching, grasping, turning, sitting, crawling, walking, taking solids, feeding self; or

B. Mental impairment as described under the criteria in 112.05 or 112.12; or

C. Growth impairment as described under the criteria in 100.02A or B; or

D. Significant interference with communication due to speech, hearing, or visual impairments as described under the criteria in 102.00 and 111.09; or

E. Cardiovascular impairments as described under the criteria in 104.00; or

F. Other impairments such as, but not limited to, malnutrition, hypothyroidism, or seizures should be evaluated under the criteria in 105.08, 109.02 or 111.02 and 111.03, or the criteria for the affected body system.

110.08 Catastrophic congenital abnormalities or disease. With:

A. A positive diagnosis (such as anencephaly, trisomy D or E, cyclopia, etc.), generally regarded as being incompatible with extrauterine life; or

B. A positive diagnosis (such as cri du chat, Tay-Sachs Disease) wherein attainment of the growth and development level of 2 years is not expected to occur.

111.00 NEUROLOGICAL

A. *Seizure disorder* must be substantiated by at least one detailed description of a typical seizure. Report of recent documentation should include an electroencephalogram and neurological examination. Sleep EEG is preferable, especially with temporal lobe seizures. Frequency of attacks and any associated phenomena should also be substantiated.

Young children may have convulsions in association with febrile illnesses. Proper use of 111.02 and 111.03 requires that a seizure dis-

order be established. Although this does not exclude consideration of seizures occurring during febrile illnesses, it does require documentation of seizures during nonfebrile periods.

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

B. *Minor motor seizures.* Classical petit mal seizures must be documented by characteristic EEG pattern, plus information as to age at onset and frequency of clinical seizures. Myoclonic seizures, whether of the typical infantile or Lennox-Gastaut variety after infancy, must also be documented by the characteristic EEG pattern plus information as to age at onset and frequency of seizures.

C. *Motor dysfunction.* As described in 111.06, motor dysfunction may be due to any neurological disorder. It may be due to static or progressive conditions involving any area of the nervous system and producing any type of neurological impairment. This may include weakness, spasticity, lack of coordination, ataxia, tremor, athetosis, or sensory loss. Documentation of motor dysfunction must include neurologic findings and description of type of neurologic abnormality (e.g., spasticity, weakness), as well as a description of the child's functional impairment (i.e., what the child is unable to do because of the abnormality). Where a diagnosis has been made, evidence should be included for substantiation of the diagnosis (e.g., blood chemistry and muscle biopsy reports), wherever applicable.

D. *Impairment of communication.* The documentation should include a description of a recent comprehensive evaluation, including all areas of affective and effective communication, performed by a qualified professional.

111.01 Category of Impairment, Neurological

111.02 Major motor seizure disorder.

A. *Major motor seizures.* In a child with an established seizure disorder, the occurrence of more than one major motor seizure per month despite at least three months of prescribed treatment. With:

1. Daytime episodes (loss of consciousness and convulsive seizures); or

2. Nocturnal episodes manifesting residuals which interfere with activity during the day.

B. *Major motor seizures.* In a child with an established seizure disorder, the occurrence of a least one major motor seizure in the year prior to application despite at least three months of prescribed treatment. And one of the following:

1. IQ of 70 or less; or

2. Significant interference with communication due to speech, hearing, or visual defect; or

3. Significant emotional disorder; or

4. Where significant adverse effects of medication interfere with major daily activities.

111.03 Minor motor seizure disorder. In a child with an established seizure disorder, the occurrence of more than one minor motor seizure per week, with alteration of awareness or loss of consciousness, despite at least three months of prescribed treatment.

111.05 Brain tumors. A. *Malignant gliomas (astrocytoma—Grades III and IV, glioblastoma multiforme), medulloblastoma, ependymoblastoma, primary sarcoma or brain stem gliomas;* or

B. Evaluate other brain tumors under the criteria for the resulting neurological impairment.

111.06 Motor dysfunction (due to any neurological disorder). Persistent disorganization or deficit of motor function for age involving two extremities, which (despite prescribed therapy) interferes with age-appropriate major daily activities and results in disruption of:

A. Fine and gross movements; or

B. Gait and station.

111.07 Cerebral palsy. With:

A. Motor dysfunction meeting the requirements of 111.06 or 101.03; or

B. Less severe motor dysfunction (but more than slight) and one of the following:

1. IQ of 70 or less; or

2. Seizure disorder, with at least one major motor seizure in the year prior to application; or

3. Significant interference with communication due to speech, hearing or visual defect; or

4. Significant emotional disorder.

111.08 Meningocele (and related disorders). With one of the following despite prescribed treatment:

A. Motor dysfunction meeting the requirements of 101.03 or 111.06; or

B. Less severe motor dysfunction (but more than slight); and:

1. Urinary or fecal incontinence when inappropriate for age; or

2. IQ of 70 or less; or

C. Four extremity involvement; or

D. Noncompensated hydrocephalus producing interference with mental or motor developmental progression.

111.09 Communication impairment, associated with documented neurological disorder. And one of the following:

A. Documented speech deficit which significantly affects the clarity and content of the speech; or

B. Documented comprehension deficit resulting in ineffective verbal communication for age; or

C. Impairment of hearing as described under the criteria in 102.08.

112.00 MENTAL DISORDERS

A. *Introduction:* The structure of the mental disorders listings for children under age 18 parallels the structure for the mental disorders listings for adults but is modified to reflect the presentation of mental disorders in children. The listings for mental disorders in children are arranged in 11 diagnostic categories: Organic mental disorders (112.02); schizophrenic, delusional (paranoid), schizoaffective, and other psychotic disorders (112.03); mood disorders (112.04); mental retardation (112.05); anxiety disorders (112.06); somatoform, eating, and tic disorders (112.07); personality disorders (112.08); psychoactive substance dependence disorders (112.09); autistic disorder and other pervasive developmental disorders (112.10); attention deficit hyperactivity disorder (112.11); and developmental and emotional disorders of newborn and younger infants (112.12).

There are significant differences between the listings for adults and the listings for children. There are disorders found in children that have no real analogy in adults; hence, the differences in the diagnostic categories for children. The presentation of mental disorders in children, particularly the very young child, may be subtle and of a character different from the signs and symptoms found in adults. For example, findings such as separation anxiety, failure to mold or bond with the parents, or withdrawal may serve as findings comparable to findings that mark mental disorders in adults. The activities appropriate to children, such as learning, growing, playing, maturing, and school adjustment, are also different from the activities appropriate to the adult and vary widely in the different childhood stages.

Each listing begins with an introductory statement that describes the disorder or disorders addressed by the listing. This is followed (except in listings 112.05 and 112.12) by medical findings (paragraph A criteria), which, if satisfied, lead to an assessment of impairment-related functional limitations (paragraph B criteria). An individual will be found to have a listed impairment when the criteria of both paragraphs A and B of the listed impairment are satisfied.

The purpose of the criteria in paragraph A is to substantiate medically the presence of a particular mental disorder. Specific symptoms and signs under any of the listings 112.02 through 112.12 cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) indicated by the medical findings.

Paragraph A of the listings is a composite of medical findings which are used to substantiate the existence of a disorder and may or may not be appropriate for children at specific developmental stages. However, a range of medical findings is included in the listings so that no age group is excluded. For example, in listing 112.02A7, emotional lability and crying would be inappropriate criteria to apply to older infants and toddlers, age 1 to attainment of age 3; whereas in 112.02A1, developmental arrest, delay, or regression are appropriate criteria for older infants and toddlers. Whenever the adjudicator decides that the requirements of paragraph A of a particular mental listing are satisfied, then that listing should be applied regardless of the age of the child to be evaluated.

The purpose of the paragraph B criteria is to describe impairment-related functional limitations which are applicable to children. Standardized tests of social or cognitive function and adaptive behavior are frequently available and appropriate for the evaluation of children and, thus, such tests are included in the paragraph B functional parameters. The functional restrictions in paragraph B must be the result of the mental disorder which is manifested by the medical findings in paragraph A.

We have not included separate C criteria for listings 112.03 and 112.06, as are found in the adult listings, because for the most part we do not believe that categories like residual schizophrenia or agoraphobia are commonly found in children. However, in unusual cases where these disorders are found in children and are comparable to the severity and duration found in adults, the adult 12.03C and 12.06C criteria may be used for evaluation of the cases.

The structure of the listings for Mental Retardation (112.05) and Developmental and Emotional Disorders of Newborn and Younger Infants (112.12) is different from that of the other mental disorders. Listing 112.05 (Mental Retardation) contains six sets of criteria, any one of which, if satisfied, will result in a finding that the child's impairment meets the listing. Listing 112.12 (Developmental and Emotional Disorders of Newborn and Younger Infants) contains five criteria, any one of which, if satisfied, will result in a finding that the infant's impairment meets the listing.

It must be remembered that these listings are examples of common mental disorders which are severe enough to find a child disabled. When a child has a medically determinable impairment that is not listed or a combination of impairments no one of which meets a listing, we will make a medical equivalency determination. (See §§ 404.1526 and 416.926.) This determination can be especially important in older infants and toddlers (age 1 to attainment of age 3), who may

be too young for identification of a specific diagnosis, yet demonstrate substantial limitations. Therefore, the notion of equivalency is necessary. Evaluation of any child's case who does not have an impairment in listing.

B. Need for Medical Evidence: If of a medically determinable impairment, the required duration must be established. Medical evidence consisting of signs, and laboratory findings (in psychological or developmental tests). Symptoms are complaints presented by the child. Psychiatric signs are demonstrable phenomena which indicate specific abnormalities of behavior, affect, thought, memory, orientation, development, and contact with reality, as described by an appropriate medical source. Symptoms and signs generally cluster together to constitute recognizable mental disorders described in paragraph A of the listings. These findings may be intermittent or continuous depending on the nature of the disorder.

C. Assessment of Severity: In childhood cases, as with adults, severity is measured according to the functional limitations imposed by the medically determinable mental impairment. However, the range of functions used to assess impairment severity for children varies at different stages of maturation. The functional areas that we consider are: Motor function; cognitive/communicative function; social function; personal/behavioral function; and concentration, persistence, and pace. In most functional areas, there are two alternative methods of documenting the required level of severity: (1) Use of standardized tests alone, where appropriate test instruments are available, and (2) use of other medical findings. (See 112.00D for explanation of these documentation requirements.) The use of standardized tests is the preferred method of documentation if such tests are available.

Newborn and younger infants (birth to attainment of age 1) have not developed sufficient personality differentiation to permit formulation of appropriate diagnoses. We have, therefore, assigned listing 112.12 for Developmental and Emotional Disorders of Newborn and Younger Infants for the evaluation of mental disorders of such children. Severity of these disorders is based on measures of development in motor, cognitive/communicative, and social functions. When older infants and toddlers (age 1 to attainment of age 3) do not clearly satisfy the paragraph A criteria of any listing because of insufficient developmental differentiation, they must be evaluated under the rules for equivalency. The principles for assessing the severity of impairment in such children, described in the following paragraphs, must be employed.

Many of the I.F.S. principles are also embodied in these mental impairment listings.

severity of functional limitations sets of paragraph B listing to two separate age groups established, in addition which is for children who are age 1. These age groups are toddlers (age 1 to attainment of age 3) and children (age 3 to attainment of age 18). However, the discussion of function, is broken down into three age groups: older infants and toddlers (age 1 to attainment of age 3), preschool children (age 3 to attainment of age 6), and adolescents (age 12 to attainment of age 18). This was done to provide specific guidance on the age group variances in disease manifestations and methods of evaluation.

Where "marked" is used as a standard for measuring the degree of limitation it means more than moderate but less than extreme. A marked limitation may arise when several activities or functions are impaired, or even when only one is impaired, as long as the degree of limitation is such as to interfere seriously with the ability to function (based upon age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis. When standardized tests are used as the measure of functional parameters, a valid score that is two standard deviations below the norm for the test will be considered a marked restriction.

1. Older infants and toddlers (age 1 to attainment of age 3). In this age group, impairment severity is assessed in three areas: (a) Motor development, (b) cognitive/communicative function, and (c) social function.

a. Motor development. Much of what we can discern about mental function in these children frequently comes from observation of the degree of development of fine and gross motor function. Developmental delay, as measured by a good developmental milestone history confirmed by medical examination, is critical. This information will ordinarily be available in the existing medical evidence from the claimant's treating sources and other medical sources, supplemented by information from nonmedical sources, such as parents, who have observed the child and can provide pertinent historical information. It may also be available from standardized testing. If the delay is such that the older infant or toddler has not achieved motor development generally acquired by children no more than one-half the child's chronological age, the criteria are satisfied.

b. Cognitive/communicative function. Cognitive/communicative function is measured using one of several standardized infant scales. Appropriate tests for the measure of such function are discussed in 112.00D. Care should be taken to avoid reliance on screening devices, which are not generally consid-

ered to be sufficiently reliable instruments, although such devices may provide some relevant data; however, there will be cases in which the results of such tests show such severe abnormalities that further testing will be unnecessary.

For older infants and toddlers, alternative criteria covering disruption in communication as measured by their capacity to use simple verbal and nonverbal structures to communicate basic needs are provided.

c. Social function. Social function in older infants and toddlers is measured in terms of the development of relatedness to people (e.g., bonding and stranger anxiety) and attachment to animate or inanimate objects. Criteria are provided that use standard social maturity scales or alternative criteria that describe marked impairment in socialization.

2. Preschool children (age 3 to attainment of age 6). For the age groups including preschool children through adolescence, the functional areas used to measure severity are: (a) Cognitive/communicative function, (b) social function, (c) personal/behavioral function, and (d) deficiencies of concentration, persistence, or pace resulting in frequent failure to complete tasks in a timely manner. After 36 months, motor function is no longer felt to be a primary determinant of mental function, although, of course, any motor abnormalities should be documented and evaluated.

a. Cognitive/communicative function. In the preschool years and beyond, cognitive function can be measured by standardized tests of intelligence, although the appropriate instrument may vary with age. A primary criterion for limited cognitive function is a valid verbal, performance, or full scale IQ of 70 or less. The listings also provide alternative criteria, consisting of tests of language development or bizarre speech patterns.

b. Social function. Social function is measured by an assessment of a child's relationships with parents, other adults, and peers. These relationships are often observed not only at home but also in preschool programs, where the child's interactions with other children and teachers come under daily scrutiny.

c. Personal/behavioral function. This function may be measured by a standardized test of adaptive behavior or by careful description of maladaptive or avoidant behaviors. These behaviors are often observed not only at home but also in preschool programs.

d. Concentration, persistence, and pace. This function may be measured through observations of the child in the course of standardized testing and in the course of play.

3. Primary school children (age 6 to attainment of age 12). The measures of function here are similar to those for preschool-age children except that the test instruments

Paragraph A of the listings is a composite of medical findings which are used to substantiate the existence of a disorder and may or may not be appropriate for children at specific developmental stages. However, a range of medical findings is included in the listings so that no age group is excluded. For example, in listing 112.02A7, emotional lability and crying would be inappropriate criteria to apply to older infants and toddlers, age 1 to attainment of age 3; whereas in 112.02A1, developmental arrest, delay, or regression are appropriate criteria for older infants and toddlers. Whenever the adjudicator decides that the requirements of paragraph A of a particular mental listing are satisfied, then that listing should be applied regardless of the age of the child to be evaluated.

The purpose of the paragraph B criteria is to describe impairment-related functional limitations which are applicable to children. Standardized tests of social or cognitive function and adaptive behavior are frequently available and appropriate for the evaluation of children and, thus, such tests are included in the paragraph B functional parameters. The functional restrictions in paragraph B must be the result of the mental disorder which is manifested by the medical findings in paragraph A.

We have not included separate C criteria for listings 112.03 and 112.06, as are found in the adult listings, because for the most part we do not believe that categories like residual schizophrenia or agoraphobia are commonly found in children. However, in unusual cases where these disorders are found in children and are comparable to the severity and duration found in adults, the adult 12.03C and 12.06C criteria may be used for evaluation of the cases.

The structure of the listings for Mental Retardation (112.05) and Developmental and Emotional Disorders of Newborn and Younger Infants (112.12) is different from that of the other mental disorders. Listing 112.05 (Mental Retardation) contains six sets of criteria, any one of which, if satisfied, will result in a finding that the child's impairment meets the listing. Listing 112.12 (Developmental and Emotional Disorders of Newborn and Younger Infants) contains five criteria, any one of which, if satisfied, will result in a finding that the infant's impairment meets the listing.

It must be remembered that these listings are examples of common mental disorders which are severe enough to find a child disabled. When a child has a medically determinable impairment that is not listed or a combination of impairments no one of which meets a listing, we will make a medical equivalency determination. (See §§ 404.1526 and 416.926.) This determination can be especially important in older infants and toddlers (age 1 to attainment of age 3), who may

be too young for identification of a specific diagnosis, yet demonstrate serious functional limitations. Therefore, the determination of equivalency is necessary to the evaluation of any child's case when the child does not have an impairment that meets a listing.

B. Need for Medical Evidence: The existence of a medically determinable impairment of the required duration must be established by medical evidence consisting of symptoms, signs, and laboratory findings (including psychological or developmental test findings). Symptoms are complaints presented by the child. Psychiatric signs are medically demonstrable phenomena which indicate specific abnormalities of behavior, affect, thought, memory, orientation, development, and contact with reality, as described by an appropriate medical source. Symptoms and signs generally cluster together to constitute recognizable mental disorders described in paragraph A of the listings. These findings may be intermittent or continuous depending on the nature of the disorder.

C. Assessment of Severity: In childhood cases, as with adults, severity is measured according to the functional limitations imposed by the medically determinable mental impairment. However, the range of functions used to assess impairment severity for children varies at different stages of maturation. The functional areas that we consider are: ~~Motor function~~ cognitive/communicative function; social function; personal/behavioral function; and concentration, persistence, and pace. In most functional areas, there are two alternative methods of documenting the required level of severity: (1) Use of standardized tests alone, where appropriate test instruments are available, and (2) use of other medical findings. (See 112.00D for explanation of these documentation requirements.) The use of standardized tests is the preferred method of documentation if such tests are available.

Newborn and younger infants (birth to attainment of age 1) have not developed sufficient personality differentiation to permit formulation of appropriate diagnoses. We have, therefore, assigned listing 112.12 for Developmental and Emotional Disorders of Newborn and Younger Infants for the evaluation of mental disorders of such children. Severity of these disorders is based on measures of development in motor, cognitive/communicative, and social functions. When older infants and toddlers (age 1 to attainment of age 3) do not clearly satisfy the paragraph A criteria of any listing because of insufficient developmental differentiation, they must be evaluated under the rules for equivalency. The principles for assessing the severity of impairment in such children, described in the following paragraphs, must be employed.

In defining the severity of functional limitations, two different sets of paragraph B criteria corresponding to two separate age groupings have been established, in addition to listing 112.12, which is for children who have not attained age 1. These age groups are: older infants and toddlers (age 1 to attainment of age 3) and children (age 3 to attainment of age 18). However, the discussion below in 112.00C1, 2, 3, and 4, on the age-appropriate areas of function, is broken down into four age groupings: older infants and toddlers (age 1 to attainment of age 3), preschool children (age 3 to attainment of age 6), primary school children (age 6 to attainment of age 12), and adolescents (age 12 to attainment of age 18). This was done to provide specific guidance on the age group variances in disease manifestations and methods of evaluation.

Where "marked" is used as a standard for measuring the degree of limitation it means more than moderate but less than extreme. A marked limitation may arise when several activities or functions are impaired, or even when only one is impaired, as long as the degree of limitation is such as to interfere seriously with the ability to function (based upon age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis. When standardized tests are used as the measure of functional parameters, a valid score that is two standard deviations below the norm for the test will be considered a marked restriction.

1. Older infants and toddlers (age 1 to attainment of age 3). In this age group, impairment severity is assessed in three areas: (a) Motor development, (b) cognitive/communicative function, and (c) social function.

a. Motor development. Much of what we can discern about mental function in these children frequently comes from observation of the degree of development of fine and gross motor function. Developmental delay, as measured by a good developmental milestone history confirmed by medical examination, is critical. This information will ordinarily be available in the existing medical evidence from the claimant's treating sources and other medical sources, supplemented by information from nonmedical sources, such as parents, who have observed the child and can provide pertinent historical information. It may also be available from standardized testing. If the delay is such that the older infant or toddler has not achieved motor development generally acquired by children no more than one-half the child's chronological age, the criteria are satisfied.

b. Cognitive/communicative function. Cognitive/communicative function is measured using one of several standardized infant scales. Appropriate tests for the measure of such function are discussed in 112.00D. Care should be taken to avoid reliance on screening devices, which are not generally consid-

ered to be sufficiently reliable instruments, although such devices may provide some relevant data; however, there will be cases in which the results of such tests show such severe abnormalities that further testing will be unnecessary.

For older infants and toddlers, alternative criteria covering disruption in communication as measured by their capacity to use simple verbal and nonverbal structures to communicate basic needs are provided.

c. Social function. Social function in older infants and toddlers is measured in terms of the development of relatedness to people (e.g., bonding and stranger anxiety) and attachment to animate or inanimate objects. Criteria are provided that use standard social maturity scales or alternative criteria that describe marked impairment in socialization.

2. Preschool children (age 3 to attainment of age 6). For the age groups including preschool children through adolescence, the functional areas used to measure severity are: (a) Cognitive/communicative function, (b) social function, (c) personal/behavioral function, and (d) deficiencies of concentration, persistence, or pace resulting in frequent failure to complete tasks in a timely manner. After 36 months, motor function is no longer felt to be a primary determinant of mental function, although, of course, any motor abnormalities should be documented and evaluated.

a. Cognitive/communicative function. In the preschool years and beyond, cognitive function can be measured by standardized tests of intelligence, although the appropriate instrument may vary with age. A primary criterion for limited cognitive function is a valid verbal, performance, or full scale IQ of 70 or less. The listings also provide alternative criteria, consisting of tests of language development or bizarre speech patterns.

b. Social function. Social function is measured by an assessment of a child's relationships with parents, other adults, and peers. These relationships are often observed not only at home but also in preschool programs, where the child's interactions with other children and teachers come under daily scrutiny.

c. Personal/behavioral function. This function may be measured by a standardized test of adaptive behavior or by careful description of maladaptive or avoidant behaviors. These behaviors are often observed not only at home but also in preschool programs.

d. Concentration, persistence, and pace. This function may be measured through observations of the child in the course of standardized testing and in the course of play.

3. Primary school children (age 6 to attainment of age 12). The measures of function here are similar to those for preschool-age children except that the test instruments

may change and the capacity to function in the school setting is supplemental information. Standardized measures of academic achievement, e.g., Wide Range Achievement Test-Revised, Peabody Individual Achievement Test, etc., may be helpful in assessing cognitive impairment. Problems in social functioning, especially in the area of peer relationships, are often observed firsthand by teachers and school nurses. As described in 112.00D, *Documentation*, school records are an excellent source of information concerning function and standardized testing and should always be sought for school-age children.

As it applies to primary school children, the intent of the functional criterion described in paragraph B2d, i.e., deficiencies of concentration, persistence, or pace resulting in failure to complete tasks in a timely manner, is to identify the child who cannot adequately function in primary school because of a mental impairment. Although grades and the need for special education placement are relevant factors which must be considered in reaching a decision under paragraph B2d, they are not conclusive. There is too much variability from school district to school district in the expected level of grading and in the criteria for special education placement to justify reliance solely on these factors.

4. *Adolescents (age 12 to attainment of age 18)*. Functional criteria parallel to those for primary school children (cognitive/communicative; social; personal/behavioral; and concentration, persistence, and pace) are the measure of severity for this age group. Testing instruments appropriate to adolescents should be used where indicated. Comparable findings of disruption of social function must consider the capacity to form appropriate, stable, and lasting relationships. If information is available about cooperative working relationships in school or at part-time or full-time work, or about the ability to work as a member of a group, it should be considered when assessing the child's social and personal/behavioral functioning. Markedly impoverished social contact, isolation, withdrawal, and inappropriate or bizarre behavior under the stress of socializing with others also constitute comparable findings.

In adolescents, the intent of the functional criterion described in paragraph B2d is the same as in primary school children. However, other evidence of this functional impairment may also be available, such as from evidence of the child's performance in work or work-like settings.

D. *Documentation*: The presence of a mental disorder in a child must be documented on the basis of reports from acceptable sources of medical evidence. See §§404.1513 and 416.913. Descriptions of functional limitations may be available from these sources, either in the form of standardized test results or in other medical findings supplied by

the sources, or both. (Medical findings consist of symptoms, signs, and laboratory findings.) Whenever possible, a medical source's findings should reflect the medical source's consideration of information from parents or other concerned individuals who are aware of the child's activities of daily living, social functioning, and ability to adapt to different settings and expectations, as well as the medical source's findings and observations on examination, consistent with standard clinical practice. As necessary, information from nonmedical sources, such as parents, should also be used to supplement the record of the child's functioning to establish the consistency of the medical evidence and longitudinality of impairment severity.

For some newborn and younger infants, it may be very difficult to document the presence or severity of a mental disorder. Therefore, with the exception of some genetic diseases and catastrophic congenital anomalies, it may be necessary to defer making a disability decision until the child attains 3 months of age in order to obtain adequate observation of behavior or affect. See, also, 110.00 of this part. This period could be extended in cases of premature infants depending on the degree of prematurity and the adequacy of documentation of their developmental and emotional status.

For infants and toddlers, programs of early intervention involving occupational, physical, and speech therapists, nurses, social workers, and special educators, are a rich source of data. They can provide the developmental milestone evaluations and records on the fine and gross motor functioning of these children. This information is valuable and can complement the medical examination by a physician or psychologist. A report of an interdisciplinary team that contains the evaluation and signature of an acceptable medical source is considered acceptable medical evidence rather than supplemental data.

In children with mental disorders, particularly those requiring special placement, school records are a rich source of data, and the required reevaluations at specified time periods can provide the longitudinal data needed to trace impairment progression over time.

In some cases where the treating sources lack expertise in dealing with mental disorders of children, it may be necessary to obtain evidence from a psychiatrist, psychologist, or pediatrician with experience and skill in the diagnosis and treatment of mental disorders as they appear in children. In these cases, however, every reasonable effort must be made to obtain the records of the treating sources, since these records will help establish a longitudinal picture that cannot be established through a single purchased examination.

A reference to standardized psychological testing indicates the use of a psychological test that has appropriate characteristics of validity, reliability, and norms, administered individually by psychologist, psychiatrist, pediatrician, or other physician specialist qualified by training and experience to perform such an evaluation. Psychological tests are best considered as sets of tasks or questions designed to elicit particular behaviors when presented in a standardized manner.

The salient characteristics of a good test are: (1) Validity, i.e., the test measures what it is supposed to measure, as determined by appropriate methods; (2) reliability, i.e., the consistency of results obtained over time with the same test and the same individual; and (3) appropriate normative data, i.e., individual test scores must be comparable to test data from other individuals or groups of a similar nature, representative of that population. In considering the validity of a test result, any discrepancies between formal test results and the child's customary behavior and daily activities should be duly noted and resolved.

Tests meeting the above requirements are acceptable for the determination of the conditions contained in these listings. The psychologist, psychiatrist, pediatrician, or other physician specialist administering the test must have a sound technical and professional understanding of the test and be able to evaluate the research documentation related to the intended application of the test.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. The IQ scores in listing 112.05 reflect values from tests of general intelligence that have a mean of 100 and a standard deviation of 15, e.g., the Wechsler series and the Revised Stanford-Binet scales. Thus, IQ's below 60 reflect a level of intellectual functioning below 99.5 percent of the general population, and IQ's of 70 and below are characteristic of approximately the lowest 2 percent of the general population. IQ's obtained from standardized tests that deviate significantly from a mean of 100 and standard deviation of 15 require conversion to the corresponding percentile rank in the general population so that the actual degree of impairment reflected by the IQ scores can be determined. In cases where more than one IQ is customarily derived from the test administered, e.g., where verbal, performance, and full scale IQ's are provided, as on the Wechsler series, the lowest of these is used in conjunction with listing 112.05.

IQ test results must also be sufficiently current for accurate assessment under 112.05. Generally, the results of IQ tests tend to stabilize by the age of 16. Therefore, IQ test results obtained at age 16 or older should be viewed as a valid indication of the child's current status, provided they are compatible

with the child's current behavior. IQ test results obtained between ages 7 and 16 should be considered current for 4 years when the tested IQ is less than 40, and for 2 years when the IQ is 40 or above. IQ test results obtained before age 7 are current for 2 years if the tested IQ is less than 40 and 1 year if at 40 or above.

Standardized intelligence test results are essential to the adjudication of all cases of mental retardation that are not covered under the provisions of listings 112.05A, 112.05B, and 112.05F. Listings 112.05A, 112.05B, and 112.05F may be the bases for adjudicating cases where the results of standardized intelligence tests are unavailable, e.g., where the child's young age or condition precludes formal standardized testing.

In conjunction with clinical examinations, sources may report the results of screening tests, i.e., tests used for gross determination of level of functioning. These tests do not have high validity and reliability and generally are not considered appropriate primary evidence for disability determinations. These screening instruments may be useful in uncovering potentially serious impairments, but generally must be supplemented by the use of formal, standardized psychological testing for the purposes of a disability determination, unless the determination is to be made on the basis of findings other than psychological test data; however, there will be cases in which the results of screening tests show such obvious abnormalities that further testing will clearly be unnecessary.

Where reference is made to developmental milestones, this is defined as the attainment of particular mental or motor skills at an age-appropriate level, i.e., the skills achieved by an infant or toddler sequentially and within a given time period in the motor and manipulative areas, in general understanding and social behavior, in self-feeding, dressing, and toilet training, and in language. This is sometimes expressed as a developmental quotient (DQ), the relation between developmental age and chronological age as determined by specific standardized measurements and observations. Such tests include, but are not limited to, the Cattell Infant Intelligence Scale, the Bayley Scales of Infant Development, and the Revised Stanford-Binet. Formal tests of the attainment of developmental milestones are generally used in the clinical setting for determination of the developmental status of infants and toddlers.

Formal psychological tests of cognitive functioning are generally in use for preschool children, for primary school children, and for adolescents except for those instances noted below.

Exceptions to formal standardized psychological testing may be considered when a psychologist, psychiatrist, pediatrician, or

other physician specialist who is qualified by training and experience to perform such an evaluation is not readily available. In such instances, appropriate medical, historical, social, and other information must be reviewed in arriving at a determination.

Exceptions may also be considered in the case of ethnic/cultural minorities where the native language or culture is not principally English-speaking. In such instances, psychological tests that are culture-free, such as the Leiter International Performance Scale or the Scale of Multi-Culture Pluralistic Assessment (SOMPA) may be substituted for the standardized tests described above. Any required tests must be administered in the child's principal language. When this is not possible, appropriate medical, historical, social, and other information must be reviewed in arriving at a determination. Furthermore, in evaluating mental impairments in children from a different culture, the best indicator of severity is often the level of adaptive functioning and how the child performs activities of daily living and social functioning.

Neuropsychological testing refers to the administration of standardized tests that are reliable and valid with respect to assessing impairment in brain functioning. It is intended that the psychologist or psychiatrist using these tests will be able to evaluate the following functions: Attention/concentration, problem-solving, language, memory, motor, visual-motor and visual-perceptual, laterality, and general intelligence (if not previously obtained).

E. Effect of Hospitalization or Residential Placement: As with adults, children with mental disorders may be placed in a variety of structured settings outside the home as part of their treatment. Such settings include, but are not limited to, psychiatric hospitals, developmental disabilities facilities, residential treatment centers and schools, community-based group homes, and workshop facilities. The reduced mental demands of such structured settings may attenuate overt symptomatology and superficially make the child's level of adaptive functioning appear better than it is. Therefore, the capacity of the child to function outside highly structured settings must be considered in evaluating impairment severity. This is done by determining the degree to which the child can function (based upon age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis outside the highly structured setting.

On the other hand, there may be a variety of causes for placement of a child in a structured setting which may or may not be directly related to impairment severity and functional ability. Placement in a structured setting in and of itself does not equate with a finding of disability. The severity of the

impairment must be compared with the requirements of the appropriate listing.

F. Effects of Medication: Attention must be given to the effect of medication on the child's signs, symptoms, and ability to function. While psychoactive medications may control certain mental disorders, impaired ability, such as the functional mental disorder, may be controlled by psychoactive medication but b. Cognitive/communicative function at a level generally acquired by children no more than one-half the child's chronological age, documented by:

(1) An appropriate standardized test; or
(2) Other medical findings of equivalent cognitive/communicative abnormality, such as the inability to use simple verbal or non-verbal behavior to communicate basic needs or concepts; or

112.01 CATEGORY OF IMPAIRMENTS, MENTAL

112.02 Organic Mental Disorders: Abnormalities in perception, cognition, affect, or behavior associated with dysfunction of the brain. The history and physical examination or laboratory tests, including psychological or neuropsychological tests, demonstrate or support the presence of an organic factor judged to be etiologically related to the abnormal mental state and associated deficit or loss of specific cognitive abilities, or affective changes, or loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence of at least one of the following:

1. Developmental arrest, delay or regression; or
2. Disorientation to time and place; or
3. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or
4. Perceptual or thinking disturbance (e.g., hallucinations, delusions, illusions, or paranoid thinking); or
5. Disturbance in personality (e.g., apathy, hostility); or
6. Disturbance in mood (e.g., mania, depression); or
7. Emotional lability (e.g., sudden crying); or
8. Impairment of impulse control (e.g., disinhibited social behavior, explosive temper outbursts); or
9. Impairment of cognitive function, as measured by clinically timely standardized psychological testing; or

Social Security Administration

10. Disturbance of concentration, attention, or judgment;

AND

B. Select the appropriate age group to evaluate the severity of the impairment:

1. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the following:

a. Gross or fine motor development at a level generally acquired by children no more than one-half the child's chronological age, documented by:

- (1) An appropriate standardized test; or
 - (2) Other medical findings (see 112.00C); or
- b. Cognitive/communicative function at a level generally acquired by children no more than one-half the child's chronological age, documented by:

- (1) An appropriate standardized test; or
- (2) Other medical findings of equivalent cognitive/communicative abnormality, such as the inability to use simple verbal or non-verbal behavior to communicate basic needs or concepts; or

c. Social function at a level generally acquired by children no more than one-half the child's chronological age, documented by:

- (1) An appropriate standardized test; or
- (2) Other medical findings of an equivalent abnormality of social functioning, exemplified by serious inability to achieve age-appropriate autonomy as manifested by excessive clinging or extreme separation anxiety; or

d. Attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas covered by a., b., or c., as measured by an appropriate standardized test or other appropriate medical findings.

2. For children (age 3 to attainment of age 18), resulting in at least two of the following:

a. Marked impairment in age-appropriate cognitive/communicative function, documented by medical findings (including consideration of historical and other information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized psychological tests, or for children under age 6, by appropriate tests of language and communication; or

b. Marked impairment in age-appropriate social functioning, documented by history and medical findings (including consideration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized tests; or

c. Marked restriction of age-appropriate activities of daily living, documented by history and medical findings (including consid-

eration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, appropriate standardized tests; or

(2) Persistent serious maladaptive behavior, destructive to self, others, animals, or property, requiring protective intervention; or

d. Deficiencies of concentration, persistence, or pace resulting in failure to complete tasks in

112.03 Schizophrenia, or other psychotic disorders, characterized by one or more of the following:

1. Delusions, or other grossly disorganized behavior; or

2. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech; or

3. Flat, blunt, or inappropriate affect; or

4. Emotional withdrawal, apathy, or isolation;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.04 Mood Disorders: Characterized by a disturbance of mood (referring to a prolonged emotion that colors the whole psychic life, generally involving either depression or elation), accompanied by a full or partial manic or depressive syndrome.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Major depressive syndrome, characterized by at least five of the following, which must include either depressed or irritable mood or markedly diminished interest or pleasure:

- a. Depressed or irritable mood; or
- b. Markedly diminished interest or pleasure in almost all activities; or
- c. Appetite or weight increase or decrease, or failure to make expected weight gains; or
- d. Sleep disturbance; or

These "B" criteria are used by almost all of the ment. imp. listings for kids - most refer you to this section

the notorious "maladaptive behavior" eliminated from the kids' ment. imp. listings

other physician specialist who is qualified by training and experience to perform such an evaluation is not readily available. In such instances, appropriate medical, historical, social, and other information must be reviewed in arriving at a determination.

Exceptions may also be considered in the case of ethnic/cultural minorities where the native language or culture is not principally English-speaking. In such instances, psychological tests that are culture-free, such as the Leiter International Performance Scale or the Scale of Multi-Culture Pluralistic Assessment (SOMPA) may be substituted for the standardized tests described above. Any required tests must be administered in the child's principal language. When this is not possible, appropriate medical, historical, social, and other information must be reviewed in arriving at a determination. Furthermore, in evaluating mental impairments in children from a different culture, the best indicator of severity is often the level of adaptive functioning and how the child performs activities of daily living and social functioning.

Neuropsychological testing refers to the administration of standardized tests that are reliable and valid with respect to assessing impairment in brain functioning. It is intended that the psychologist or psychiatrist using these tests will be able to evaluate the following functions: Attention/concentration, problem-solving, language, memory, motor, visual-motor and visual-perceptual, laterality, and general intelligence (if not previously obtained).

E. Effect of Hospitalization or Residential Placement: As with adults, children with mental disorders may be placed in a variety of structured settings outside the home as part of their treatment. Such settings include, but are not limited to, psychiatric hospitals, developmental disabilities facilities, residential treatment centers and schools, community-based group homes, and workshop facilities. The reduced mental demands of such structured settings may attenuate overt symptomatology and superficially make the child's level of adaptive functioning appear better than it is. Therefore, the capacity of the child to function outside highly structured settings must be considered in evaluating impairment severity. This is done by determining the degree to which the child can function (based upon age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis outside the highly structured setting.

On the other hand, there may be a variety of causes for placement of a child in a structured setting which may or may not be directly related to impairment severity and functional ability. Placement in a structured setting in and of itself does not equate with a finding of disability. The severity of the

impairment must be compared with the requirements of the appropriate listing.

F. Effects of Medication: Attention must be given to the effect of medication on the child's signs, symptoms, and ability to function. While psychoactive medications may control certain primary manifestations of a mental disorder, e.g., hallucinations, impaired attention, restlessness, or hyperactivity, such treatment may or may not affect the functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the psychoactive medications, particular attention must be focused on the functional limitations which may persist. These functional limitations must be considered in assessing impairment severity.

Psychotropic medicines used in the treatment of some mental illnesses may cause drowsiness, blunted affect, or other side effects involving other body systems. Such side effects must be considered in evaluating overall impairment severity.

112.01 CATEGORY OF IMPAIRMENTS, MENTAL

112.02 Organic Mental Disorders: Abnormalities in perception, cognition, affect, or behavior associated with dysfunction of the brain. The history and physical examination or laboratory tests, including psychological or neuropsychological tests, demonstrate or support the presence of an organic factor judged to be etiologically related to the abnormal mental state and associated deficit or loss of specific cognitive abilities, or affective changes, or loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence of at least one of the following:

1. Developmental arrest, delay or regression; or
2. Disorientation to time and place; or
3. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or
4. Perceptual or thinking disturbance (e.g., hallucinations, delusions, illusions, or paranoid thinking); or
5. Disturbance in personality (e.g., apathy, hostility); or
6. Disturbance in mood (e.g., mania, depression); or
7. Emotional lability (e.g., sudden crying); or
8. Impairment of impulse control (e.g., disinhibited social behavior, explosive temper outbursts); or
9. Impairment of cognitive function, as measured by clinically timely standardized psychological testing; or

Social Security Administration

10. Disturbance of concentration, attention, or judgment;

AND

B. Select the appropriate age group to evaluate the severity of the impairment:

1. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the following:

a. Gross or fine motor development at a level generally acquired by children no more than one-half the child's chronological age, documented by:

- (1) An appropriate standardized test; or
- (2) Other medical findings (see 112.00C); or

b. Cognitive/communicative function at a level generally acquired by children no more than one-half the child's chronological age, documented by:

- (1) An appropriate standardized test; or
- (2) Other medical findings of equivalent cognitive/communicative abnormality, such as the inability to use simple verbal or non-verbal behavior to communicate basic needs or concepts; or

c. Social function at a level generally acquired by children no more than one-half the child's chronological age, documented by:

- (1) An appropriate standardized test; or
- (2) Other medical findings of an equivalent abnormality of social functioning, exemplified by serious inability to achieve age-appropriate autonomy as manifested by excessive clinging or extreme separation anxiety; or

d. Attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas covered by a., b., or c., as measured by an appropriate standardized test or other appropriate medical findings.

2. For children (age 3 to attainment of age 18), resulting in at least two of the following:

a. Marked impairment in age-appropriate cognitive/communicative function, documented by medical findings (including consideration of historical and other information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized psychological tests, or for children under age 6, by appropriate tests of language and communication; or

b. Marked impairment in age-appropriate social functioning, documented by history and medical findings (including consideration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized tests; or

c. Marked impairment in personal/behavioral function, as evidenced by:

- (1) Marked restriction of age-appropriate activities of daily living, documented by history and medical findings (including consid-

eration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, appropriate standardized tests; or

(2) Persistent serious maladaptive behaviors destructive to self, others, animals, or property, requiring protective intervention; or

d. Deficiencies of concentration, persistence, or pace resulting in frequent failure to complete tasks in a timely manner.

112.03 Schizophrenic, Delusional (Paranoid), Schizoaffective, and Other Psychotic Disorders: Onset of psychotic features, characterized by a marked disturbance of thinking, feeling, and behavior, with deterioration from a previous level of functioning or failure to achieve the expected level of social functioning.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, for at least 6 months, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or
2. Catatonic, bizarre, or other grossly disorganized behavior; or
3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech; or
4. Flat, blunt, or inappropriate affect; or
5. Emotional withdrawal, apathy, or isolation;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.04 Mood Disorders: Characterized by a disturbance of mood (referring to a prolonged emotion that colors the whole psychic life, generally involving either depression or elation), accompanied by a full or partial manic or depressive syndrome.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Major depressive syndrome, characterized by at least five of the following, which must include either depressed or irritable mood or markedly diminished interest or pleasure:

- a. Depressed or irritable mood; or
- b. Markedly diminished interest or pleasure in almost all activities; or
- c. Appetite or weight increase or decrease, or failure to make expected weight gains; or
- d. Sleep disturbance; or

PHOTOCOPY
PRESERVATION

e. Psychomotor agitation or retardation; or

f. Fatigue or loss of energy; or
g. Feelings of worthlessness or guilt; or
h. Difficulty thinking or concentrating; or
i. Suicidal thoughts or acts; or
j. Hallucinations, delusions, or paranoid thinking;

OR

2. Manic syndrome, characterized by elevated, expansive, or irritable mood, and at least three of the following:

a. Increased activity or psychomotor agitation; or
b. Increased talkativeness or pressure of speech; or
c. Flight of ideas or subjectively experienced racing thoughts; or
d. Inflated self-esteem or grandiosity; or
e. Decreased need for sleep; or
f. Easy distractibility; or
g. Involvement in activities that have a high potential of painful consequences which are not recognized; or
h. Hallucinations, delusions, or paranoid thinking;

OR

3. Bipolar or cyclothymic syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently or most recently characterized by the full or partial symptomatic picture of either or both syndromes);

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.05 *Mental Retardation*: Characterized by significantly subaverage general intellectual functioning with deficits in adaptive functioning.

The required level of severity for this disorder is met when the requirements in A, B, C, D, E, or F are satisfied.

A. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02;

OR

B. Mental incapacity evidenced by dependence upon others for personal needs (grossly in excess of age-appropriate dependence) and inability to follow directions such that the use of standardized measures of intellectual functioning is precluded;

OR

C. A valid verbal, performance, or full scale IQ of 59 or less;

OR

D. A valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing additional and significant limitation of function;

OR

E. A valid verbal, performance, or full scale IQ of 60 through 70 and:

1. For older infants and toddlers (age 1 to attainment of age 3), resulting in attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in either paragraphs B1a or B1c of 112.02; or

2. For children (age 3 to attainment of age 18), resulting in at least one of paragraphs B2b or B2c or B2d of 112.02; *too tough 2 mks*

OR

F. Select the appropriate age group:

1. For older infants and toddlers (age 1 to attainment of age 3), resulting in attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in paragraph B1b of 112.02, and a physical or other mental impairment imposing additional and significant limitations of function;

OR

2. For children (age 3 to attainment of age 18), resulting in the satisfaction of 112.02B2a, and a physical or other mental impairment imposing additional and significant limitations of function.

112.06 *Anxiety Disorders*: In these disorders, anxiety is either the predominant disturbance or is experienced if the individual attempts to master symptoms, e.g., confronting the dreaded object or situation in a phobic disorder, attempting to go to school in a separation anxiety disorder, resisting the obsessions or compulsions in an obsessive compulsive disorder, or confronting strangers or peers in avoidant disorders.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of at least one of the following:

1. Excessive anxiety manifested when the child is separated, or separation is threatened, from a parent or parent surrogate; or

2. Excessive and persistent avoidance of strangers; or

3. Persistent unrealistic or excessive anxiety and worry (apprehensive expectation), accompanied by motor tension, autonomic hyperactivity, or vigilance and scanning; or

4. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

Social Security Administration

5. Recurrent severe panic attacks, manifested by a sudden unpredictable onset of intense apprehension, fear, or terror, often with a sense of impending doom, occurring on the average of at least once a week; or

6. Recurrent obsessions or compulsions which are a source of marked distress; or

7. Recurrent and intrusive recollections of a traumatic experience, including dreams, which are a source of marked distress;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.07 *Somatoform, Eating, and Tic Disorders*: Manifested by physical symptoms for which there are no demonstrable organic findings or known physiologic mechanisms; or eating or tic disorders with physical manifestations.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of one of the following:

1. An unrealistic fear and perception of fatness despite being underweight, and persistent refusal to maintain a body weight which is greater than 85 percent of the average weight for height and age, as shown in the most recent edition of the *Nelson Textbook of Pediatrics*, Richard E. Behrman and Victor C. Vaughan, III, editors, Philadelphia: W. B. Saunders Company; or

2. Persistent and recurrent involuntary, repetitive, rapid, purposeless motor movements affecting multiple muscle groups with multiple vocal tics; or

3. Persistent nonorganic disturbance of one of the following:

a. Vision; or
b. Speech; or
c. Hearing; or
d. Use of a limb; or
e. Movement and its control (e.g., coordination disturbance, psychogenic seizures); or
f. Sensation (diminished or heightened); or
g. Digestion or elimination; or
4. Preoccupation with a belief that one has a serious disease or injury;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.08 *Personality Disorders*: Manifested by pervasive, inflexible, and maladaptive personality traits, which are typical of the

child's long-term functioning and not limited to discrete episodes of illness.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Deeply ingrained, maladaptive patterns of behavior, associated with one of the following:

1. Seclusiveness or autistic thinking; or
2. Pathologically inappropriate suspiciousness or hostility; or
3. Oddities of thought, perception, speech, and behavior; or
4. Persistent disturbances of mood or affect; or
5. Pathological dependence, passivity, or aggressiveness; or
6. Intense and unstable interpersonal relationships and impulsive and exploitative behavior; or
7. Pathological perfectionism and inflexibility;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.09 *Psychoactive Substance Dependence Disorders*: Manifested by a cluster of cognitive, behavioral, and physiologic symptoms that indicate impaired control of psychoactive substance use with continued use of the substance despite adverse consequences.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of at least four of the following:

1. Substance taken in larger amounts or over a longer period than intended and a great deal of time is spent in recovering from its effects; or

2. Two or more unsuccessful efforts to cut down or control use; or

3. Frequent intoxication or withdrawal symptoms interfering with major role obligations; or

4. Continued use despite persistent or recurring social, psychological, or physical problems; or

5. Tolerance, as characterized by the requirement for markedly increased amounts of substance in order to achieve intoxication; or

6. Substance taken to relieve or avoid withdrawal symptoms;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least

two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.10 Autistic Disorder and Other Pervasive Developmental Disorders: Characterized by qualitative deficits in the development of reciprocal social interaction, in the development of verbal and nonverbal communication skills, and in imaginative activity. Often, there is a markedly restricted repertoire of activities and interests, which frequently are stereotyped and repetitive.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of the following:

1. For autistic disorder, all of the following:

a. Qualitative deficits in the development of reciprocal social interaction; and

b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity; and

c. Markedly restricted repertoire of activities and interests;

OR

2. For pervasive developmental disorders, both of the following:

a. Qualitative deficits in the development of social interaction; and

b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraphs B2 of 112.02.

112.11 Attention Deficit Hyperactivity Disorder: Manifested by developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of all three of the following:

1. Marked inattention; and

2. Marked impulsiveness; and

3. Marked hyperactivity;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.12 Developmental and Emotional Disorders of Newborn and Younger Infants (Birth to attainment of age 1): Developmental or emotional disorders of infancy are evidenced

by a deficit or lag in the areas of motor, cognitive/communicative, or social functioning. These disorders may be related either to organic or to functional factors or to a combination of these factors.

The required level of severity for these disorders is met when the requirements of A, B, C, D, or E are satisfied.

A. Cognitive/communicative functioning generally acquired by children no more than one-half the child's chronological age, as documented by appropriate medical findings (e.g., in infants 0-6 months, markedly diminished variation in the production or imitation of sounds and severe feeding abnormality, such as problems with sucking, swallowing, or chewing) including, if necessary, a standardized test;

OR

B. Motor development generally acquired by children no more than one-half the child's chronological age, documented by appropriate medical findings, including if necessary, a standardized test;

OR

C. Apathy, over-excitability, or fearfulness, demonstrated by an absent or grossly excessive response to one of the following:

1. Visual stimulation; or

2. Auditory stimulation; or

3. Tactile stimulation;

OR

D. Failure to sustain social interaction on an ongoing, reciprocal basis as evidenced by:

1. Inability by 6 months to participate in vocal, visual, and motoric exchanges (including facial expressions); or

2. Failure by 9 months to communicate basic emotional responses, such as cuddling or exhibiting protest or anger; or

3. Failure to attend to the caregiver's voice or face or to explore an inanimate object for a period of time appropriate to the infant's age;

OR

E. Attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas (i.e., cognitive/communicative, motor, and social), documented by appropriate medical findings, including if necessary, standardized testing.

113.00 NEOPLASTIC DISEASES, MALIGNANT

A. *Introduction.* Determination of disability in the growing and developing child with a malignant neoplastic disease is based upon the combined effects of:

1. The pathophysiology, histology, and natural history of the tumor; and

2. The effects of the currently employed aggressive multimodal therapeutic regimens.

Combinations of surgery, radiation, and chemotherapy or prolonged therapeutic

Social Security Administration

schedules impart significant additional morbidity to the child during the period of greatest risk from the tumor itself. This period of highest risk and greatest therapeutically-induced morbidity defines the limits of disability for most of childhood neoplastic disease.

B. *Documentation.* The diagnosis of neoplasm should be established on the basis of symptoms, signs, and laboratory findings. The site of the primary, recurrent, and metastatic lesion must be specified in all cases of malignant neoplastic diseases. If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen, along with all pertinent laboratory and X-ray reports. The evidence should also include a recent report directed especially at describing whether there is evidence of local or regional recurrence, soft part or skeletal metastases, and significant post therapeutic residuals.

C. *Malignant solid tumors*, as listed under 113.03, include the histiocytosis syndromes except for solitary eosinophilic granuloma. Thus, 113.03 should not be used for evaluating brain tumors (see 111.05) or thyroid tumors, which must be evaluated on the basis of whether they are controlled by prescribed therapy.

D. *Duration of disability* from malignant neoplastic tumors is included in 113.02 and 113.03. Following the time periods designated in these sections, a documented diagnosis itself is no longer sufficient to establish a severe impairment. The severity of a remaining impairment must be evaluated on the basis of the medical evidence.

113.01 Category of Impairments, Neoplastic Diseases—Malignant

113.02 Lymphoreticular malignant neoplasms.

A. Hodgkin's disease with progressive disease not controlled by prescribed therapy; or

B. Non-Hodgkin's lymphoma. Consider under a disability:

1. For 2½ years from time of initial diagnosis; or

2. For 2½ years from time of recurrence of active disease.

113.03 Malignant solid tumors. Consider under a disability:

A. For 2 years from the time of initial diagnosis; or

B. For 2 years from the time of recurrence of active disease.

113.04 Neuroblastoma. With one of the following:

A. Extension across the midline; or

B. Distant metastases; or

C. Recurrence; or

D. Onset at age 1 year or older.

113.05 Retinoblastoma. With one of the following:

A. Bilateral involvement; or

B. Metastases; or

C. Extension beyond the orbit; or
D. Recurrence.

114.00 IMMUNE SYSTEM

A. Listed disorders include impairments involving deficiency of one or more components of the immune system (i.e., antibody-producing B cells; a number of different types of cells associated with cell-mediated immunity including T-lymphocytes, macrophages and monocytes; and components of the complement system).

B. Dysregulation of the immune system may result in the development of a connective tissue disorder. Connective tissue disorders include several chronic multisystem disorders that differ in their clinical manifestation, course, and outcome. These disorders are described in part A, 14.00B.

Some of the features of connective tissue disorders in children may differ from the features in adults. When the clinical features are the same as that seen in adults, the principles and concepts in part A, 14.00B apply.

The documentation needed to establish the existence of a connective tissue disorder is medical history, physical examination, selected laboratory studies, medically acceptable imaging techniques and, in some instances, tissue biopsy. However, the Social Security Administration will not purchase diagnostic tests or procedures that may involve significant risk, such as biopsies or angiograms. Generally, the existing medical evidence will contain this information.

In addition to the limitations caused by the connective tissue disorder *per se*, the chronic adverse effects of treatment (e.g., corticosteroid-related ischemic necrosis of bone) may result in functional loss.

A longitudinal clinical record of at least 3 months demonstrating active disease despite prescribed treatment during this period with the expectation that the disease will remain active for 12 months is necessary for assessment of severity and duration of impairment.

In children the impairment may affect growth, development, attainment of age-appropriate skills, and performance of age-appropriate activities. The limitations may be the result of loss of function or failure in a single organ or body system, or a lesser degree of functional loss in two or more organs/body systems that, in combination with significant constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss, results in listing-level limitations. We use the term "severe" in these listings to describe medical severity; the term does not have the same meaning as it does when we use it in connection with a finding at the second step of the sequential evaluation processes in §§404.1520, 416.920, and 416.924.

C. Allergies, growth impairments and Kawasaki disease.

1. Allergic disorders (e.g., asthma or atopic dermatitis) are discussed and evaluated under the appropriate listing of the affected body system.

2. If growth is affected by the disorder or its treatment by immunosuppressive drugs, 100.00 may apply.

3. Kawasaki disease, also known as mucocutaneous lymph node syndrome, is characterized by multisystem manifestations, but significant functional impairment is usually due to disease of the coronary arteries, which should be evaluated under 104.00.

D. Human immunodeficiency virus (HIV) infection.

1. HIV infection is caused by a specific retrovirus and may be characterized by susceptibility to one or more opportunistic diseases, cancers, or other conditions, as described in 114.08. Any child with HIV infection, including one with a diagnosis of acquired immunodeficiency syndrome (AIDS), may be found disabled under this listing if his or her impairment meets any of the criteria in 114.08 or is of equivalent severity to an impairment in 114.08.

2. Definitions. In 114.08, the terms "resistant to treatment," "recurrent," and "disseminated" have the same general meaning as used by the medical community. The precise meaning of any of these terms will depend upon the specific disease or condition in question, the body system affected, the usual course of the disorder and its treatment, and the other circumstances of the case.

"Resistant to treatment" means that a condition did not respond adequately to an appropriate course of treatment. Whether a response is adequate, or a course of treatment appropriate, will depend on the facts of the particular case.

"Recurrent" means that a condition that responded adequately to an appropriate course of treatment has returned after a period of remission or regression. The extent of response (or remission) and the time periods involved will depend on the facts of the particular case.

"Disseminated" means that a condition is spread widely over a considerable area or body system(s). The type and extent of the spread will depend on the specific disease.

3. Documentation of HIV infection in children. The medical evidence must include documentation of HIV infection. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

a. Documentation of HIV infection in children by definitive diagnosis. A definitive diagnosis of HIV infection in children is documented by one or more of the following laboratory tests:

i. For a child 24 months of age or older, a serum specimen that contains HIV antibodies. HIV antibodies are usually detected by a screening test. The most commonly used screening test is the ELISA. Although this test is highly sensitive, it may yield false positive results. Therefore, positive results from an ELISA must be confirmed by a more definitive test (e.g., Western blot, immunofluorescence assay). (See paragraph b, below, for information about HIV antibody testing in children younger than 24 months of age).

ii. A specimen that contains HIV antigen (e.g., serum specimen, lymphocyte culture, or cerebrospinal fluid (CSF) specimen).

iii. An immunoglobulin A (IgA) serological assay specific for HIV.

iv. Other test(s) that are highly specific for detection of HIV in children (e.g., polymerase chain reaction (PCR)), or that are acceptable methods of detection consistent with the prevailing state of medical knowledge.

When laboratory testing for HIV infection has been performed, every reasonable effort must be made to obtain reports of the results of that testing.

b. Other acceptable documentation of HIV infection in children.

As noted in paragraph a, above, HIV infection is not documented in children under 24 months of age by a serum specimen containing HIV antibodies. This is because women with HIV infection often transfer HIV antibodies to their newborns. The mother's antibodies can persist in the infant for up to 24 months, even if the infant is not HIV-infected. Only 20 to 30 percent of such infants are actually infected. Therefore, the presence of serum HIV antibodies alone does not establish the presence of HIV infection in a child under 24 months of age. However, the presence of HIV antibodies accompanied by evidence of significantly depressed T-helper lymphocytes (CD4), an abnormal CD4/CD8 ratio, or abnormal immunoglobulin G (IgG) may be used to document HIV infection in a child under 24 months of age, even though such testing is not a basis for a definitive diagnosis.

For children from birth to the attainment of 24 months of age who have tested positive for HIV antibodies (see D3a above), HIV infection may be documented by one or more of the following:

i. For an infant 12 months of age or less, a CD4 (T4) count of 1500/mm³ or less, or a CD4 count less than or equal to 20 percent of total lymphocytes.

ii. For an infant from 12 to 24 months of age, a CD4 (T4) count of 750/mm³ or less, or a CD4 count less than or equal to 20 percent of total lymphocytes.

iii. An abnormal CD4/CD8 ratio.

iv. An IgG significantly greater than or less than the normal range for age.

HIV infection in children may also be documented without the definitive laboratory evidence described in paragraph a, or the other laboratory evidence discussed above, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence. If such laboratory evidence is not available, HIV infection may be documented by the medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence. For example, a diagnosis of HIV infection in children will be accepted without definitive laboratory evidence if the child has an opportunistic disease (e.g., *Pneumocystis carinii* pneumonia (PCP)) predictive of a defect in cell-mediated immunity, and there is no other known cause of diminished resistance to that disease (e.g., long-term steroid treatment, lymphoma). In such cases, every reasonable effort must be made to obtain full details of the history, medical findings, and results of testing.

4. Documentation of the manifestations of HIV infection in children. The medical evidence must also include documentation of the manifestations of HIV infection in children. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

a. Documentation of the manifestations of HIV infection in children by definitive diagnosis.

The definitive method of diagnosing opportunistic diseases or conditions that are manifestations of HIV infection in children is by culture, serological test, or microscopic examination of biopsied tissue or other material (e.g., bronchial washings). Therefore, every reasonable effort must be made to obtain specific laboratory evidence of an opportunistic disease or other condition whenever this information is available. If a histological or other test has been performed, the evidence should include a copy of the appropriate report. If the report is not obtainable, the summary of hospitalization or a report from the treating source should include details of the findings and results of the diagnostic studies (including radiographic studies) or microscopic examination of the appropriate tissues or body fluids.

Although a reduced CD4 lymphocyte count in a child may show that there is an increased susceptibility to opportunistic infections and diseases, that alone does not document the presence, severity, or functional effects of a manifestation of HIV infection in a child.

b. Other acceptable documentation of the manifestations of HIV infection in children.

Manifestations of HIV infection in children may also be documented without the definitive laboratory evidence described in paragraph a, provided that such documentation

is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence. If no definitive laboratory evidence is available, manifestations of HIV infection may be documented by medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence. In such cases, every reasonable effort must be made to obtain full details of the history, medical findings, and results of testing.

Documentation of cytomegalovirus (CMV) disease (114.08D) presents special problems because diagnosis requires identification of viral inclusion bodies or a positive culture from the affected organ, and the absence of any other infectious agent. A positive serology test identifies infection with the virus, but does not confirm a disease process. With the exception of chorioretinitis (which may be diagnosed by an ophthalmologist), documentation of CMV disease requires confirmation by biopsy or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

5. HIV infection in children. The clinical manifestation and course of disease in children who become infected with HIV perinatally or in the first 6 years of life may differ from that in older children and adults. In addition, survival times are shorter for children infected in the first year of life compared to those who become infected as older children or as adults. Infants may present with failure to thrive or *pneumocystis carinii* pneumonia (PCP); young children may present with recurrent infections, neurological problems, or developmental abnormalities. Older children may also exhibit neurological abnormalities, such as HIV encephalopathy, or failure to thrive.

The methods of identifying and evaluating neurological abnormalities may vary depending on a child's age. For example, in an infant, impaired brain growth can be documented by a decrease in the growth rate of the head. In older children, impaired brain growth can be documented by brain atrophy on a CAT scan. Neurological abnormalities can also be observed in a younger child in the loss of previously acquired, or marked delays in achieving, developmental milestones. In an older child, this type of neurological abnormality would generally be demonstrated by the loss of previously acquired intellectual abilities. Although loss of previously acquired intellectual abilities can be documented by a decrease in intelligence quotient (IQ) scores or demonstrated if a child forgets information he or she previously learned, it can also be shown if the child is unable to learn new information. This could include the sudden acquisition of a new learning disability.

Children with HIV infection may contract any of a broad range of bacterial infections. Certain major infections caused by pyogenic

bacteria, e.g., some pneumonias, can be severely limiting, especially in pre-adolescent children. These major bacterial infections should be evaluated under 114.08A5, which requires two or more such infections within a 2-year period. Although 114.08A5 applies only to children less than 13 years of age, an older child may be found to have an impairment of equivalent severity if the circumstances of the case warrant (e.g., delayed puberty).

Otherwise, bacterial infections are evaluated under 114.08A6. The criteria of the listing are met if one or more bacterial infection(s) occurs and requires hospitalization or intravenous antibiotic treatment 3 or more times in 1 year. Pelvic inflammatory disease in older female children should be evaluated under multiple or recurrent bacterial infections (114.08A6).

6. Evaluation of HIV infection in children. The criteria in 114.08 do not describe the full spectrum of diseases or conditions manifested by children with HIV infection. As in any case, consideration must be given to whether a child's impairment(s) meets or equals in severity any other listing in appendix 1 of subpart P (e.g., a neoplastic disorder listed in 113.00ff). Although 114.08 includes cross-references to other listings for the more common manifestations of HIV infection, additional listings may also apply.

In addition, the impact of all impairments, whether or not related to the HIV infection, must be considered. Children with HIV infection may manifest signs and symptoms of a mental impairment (e.g., anxiety, depression), or of another physical impairment. Medical evidence should include documentation of all physical and mental impairments and the impairment(s) should be evaluated not only under the relevant listing(s) in 114.08, but under any other appropriate listing(s).

It is also important to remember that children with HIV infection, like all others, are evaluated under the full sequential evaluation process described in §16.924. If a child with HIV infection is working and engaging in substantial gainful activity (SGA), or does not have a severe impairment, the case will be decided at the first or second step of the sequential evaluation process, and does not require evaluation under these listings. For a child with HIV infection who is not engaging in SGA and has a severe impairment, but whose impairment(s) does not meet the criteria of a listing, consideration will be given to whether the child's impairment or combination of impairments is either medically or functionally equivalent in severity to any listed impairment. If the child's impairment or impairments do not meet or equal a listing in severity, evaluation must proceed through the final step(s) of the sequential evaluation process (or, as appropriate, the steps in the medical improvement review

standard) before any conclusion can be reached on the issue of disability.

7. Effect of treatment. Medical treatment must be considered in terms of its effectiveness in ameliorating the signs, symptoms, and laboratory abnormalities of the specific disorder, or of the HIV infection itself (e.g. antiretroviral agents) and in terms of any side effects of treatment that may further impair the child.

Response to treatment and adverse or beneficial consequences of treatment may vary widely. For example, a child with HIV infection who develops otitis media may respond to the same antibiotic regimen used in treating children without HIV infection, but another child with HIV infection may not respond to the same regimen. Therefore, each case must be considered on an individual basis, along with the effects of treatment on the child's ability to function.

A specific description of the drugs or treatment given (including surgery), dosage, frequency of administration, and a description of the complications or response to treatment should be obtained. The effects of treatment may be temporary or long-term. As such, the decision regarding the impact of treatment should be based on a sufficient period of treatment to permit proper consideration.

8. Functional criteria. Paragraph O of 114.08 establishes standards for evaluating manifestations of HIV infection that do not meet the requirements listed in 114.08A-N. Paragraph O is applicable for manifestations that are not listed in 114.08A-N, as well as those listed in 114.08A-N that do not meet the criteria of any of the rules in 114.08A-N.

For children with HIV infection evaluated under 114.08O, listing-level severity will be assessed in terms of the functional limitations imposed by the impairment. The full impact of signs, symptoms, and laboratory findings on the child's ability to function must be considered. Important factors to be considered in evaluating the functioning of children with HIV infection include, but are not limited to: symptoms, such as fatigue and pain; characteristics of the illness, such as the frequency and duration of manifestations or periods of exacerbation and remission in the disease course; and the functional impact of treatment for the disease, including the side effects of medication.

To meet the criteria in 114.08O, a child with HIV infection must demonstrate a level of restriction in either one or two (depending on the child's age) of the general areas of functioning applicable to the child's age group. (See 112.00C for additional discussion of these areas of functioning).

114.01 Category of Impairments, Immune System

114.02 Systemic lupus erythematosus. Documented as described in 14.00B1 and 114.00B, with:

- A. One of the following:
 1. Growth impairment, as described under the criteria in 100.00ff; or
 2. Musculoskeletal involvement, as described under the criteria in 101.00ff; or
 3. Muscle involvement, as described under the criteria in 14.05; or
 4. Ocular involvement, as described under the criteria in 102.00ff; or
 5. Respiratory involvement, as described under the criteria in 103.00ff; or
 6. Cardiovascular involvement, as described under the criteria in 104.00ff or 14.04D; or
 7. Digestive involvement, as described under the criteria in 105.00ff; or
 8. Renal involvement, as described under the criteria in 106.00ff; or
 9. Hematologic involvement, as described under the criteria in 107.00ff; or
 10. Skin involvement, as described under the criteria in 8.00ff; or
 11. Endocrine involvement, as described under the criteria in 109.00ff; or
 12. Neurological involvement, as described under the criteria in 111.00ff; or
 13. Mental involvement, as described under the criteria in 112.00ff.

or

B. Lesser involvement of two or more organs/body systems listed in paragraph A, with significant, documented, constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. At least one of the organs/body systems must be involved to at least a moderate level of severity.

114.03 Systemic vasculitis. As described under the criteria in 14.03 or, if growth impairment, as described under the criteria in 100.00ff.

114.04 Systemic sclerosis and scleroderma. Documented as described in 14.00B3 and 114.00B, and:

A. As described under the criteria in 14.04 or, if growth impairment, as described under the criteria in 100.00ff.

or

B. Linear scleroderma, with one of the following:

1. Fixed valgus or varus deformities of both hands or both feet; or
2. Marked destruction or marked atrophy of an extremity; or
3. Facial disfigurement from hypoplasia of the mandible, maxilla, or zygoma resulting in an impairment as described under the criteria in 112.00ff; or
4. Seizure disorder, as described under the criteria in 111.00ff.

114.05 Polymyositis or dermatomyositis. Documented as described in 14.00B4 and 114.00B, and:

A. As described under the criteria in 14.05.

or

B. With one of the following:

1. Multiple joint contractures; or
2. Diffuse cutaneous calcification with formation of an exoskeleton; or
3. Systemic vasculitis as described under the criteria in 14.03.

114.06 Undifferentiated connective tissue disorder. As described under the criteria in 114.02 or 114.04.

114.07 Congenital immune deficiency disease. A. Hypogammaglobulinemia or dysgammaglobulinemia, with:

1. Documented, recurrent severe infections occurring 3 or more times within a 5-month period; or
2. An associated disorder such as growth retardation, chronic lung disease, collagen disorder or tumor. Evaluate according to the appropriate body system listing.

or

B. Thymic dysplastic syndromes (such as Swiss, diGeorge).

114.08 Human immunodeficiency virus (HIV) infection. With documentation as described in 114.00D3 and one of the following:

A. Bacterial infections:

1. Mycobacterial infection (e.g., caused by *M. avium*-intracellular, *M. kansasii*, or *M. tuberculosis*) at a site other than the lungs, skin, or cervical or hilar lymph nodes; or pulmonary tuberculosis resistant to treatment; or
2. Nocardiosis; or
3. *Salmonella* bacteremia, recurrent nontyphoid.

4. Syphilis or neurosyphilis—evaluate sequelae under the criteria for the affected body system (e.g., 102.00 Special Senses and Speech, 104.00 Cardiovascular System, 111.00 Neurological); or

5. In a child less than 13 years of age, multiple or recurrent pyogenic bacterial infection(s) of the following types: sepsis, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses) occurring 2 or more times in 2 years; or

6. Other multiple or recurrent bacterial infection(s), including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in 1 year.

or

B. Fungal infections:

1. Aspergillosis; or
2. Candidiasis, at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs; or

3. Coccidioidomycosis, at a site other than the lungs or lymph nodes; or
4. Cryptococcosis, at a site other than the lungs (e.g., cryptococcal meningitis); or
5. Histoplasmosis, at a site other than the lungs or lymph nodes; or
6. Mucormycosis.

or

- C. Protozoan or helminthic infections:
 1. Cryptosporidiosis, isosporiasis, or microsporidiosis, with diarrhea lasting for 1 month or longer; or
 2. Pneumocystis carinii pneumonia or extrapulmonary pneumocystis carinii infection; or
 3. Strongyloidiasis, extra-intestinal; or
 4. Toxoplasmosis of an organ other than the liver, spleen, or lymph nodes.

or

- D. Viral infections:
 1. Cytomegalovirus disease (documented as described in 114.00D4b) at a site other than the liver, spleen, or lymph nodes; or
 2. Herpes simplex virus causing:
 - a. Mucocutaneous infection (e.g., oral, genital, perianal) lasting for 1 month or longer; or

- b. Infection at a site other than the skin or mucous membranes (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or
 - c. Disseminated infection; or
3. Herpes zoster, either disseminated or with multidermatomal eruptions that are resistant to treatment; or

4. Progressive multifocal leukoencephalopathy; or
5. Hepatitis, as described under the criteria of 105.05.

or

- E. Malignant neoplasms:
 1. Carcinoma of the cervix, invasive, FIGO stage II and beyond; or
 2. Kaposi's sarcoma with:
 - a. Extensive oral lesions; or
 - b. Involvement of the gastrointestinal tract, lungs, or other visceral organs; or
 - c. Involvement of the skin or mucous membranes as described under the criteria of 114.08F; or
 3. Lymphoma (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other Non-Hodgkin's lymphoma, Hodgkin's disease); or
 4. Squamous cell carcinoma of the anus.

or

- F. Conditions of the skin or mucous membranes (other than described in B2, D2, or D3 above) with extensive fungating or ulcerating lesions not responding to treatment (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative

disease), or evaluate under the criteria in 8.00ff.

or

- G. Hematologic abnormalities:
 1. Anemia, as described under the criteria in 7.02; or
 2. Granulocytopenia, as described under the criteria in 7.15; or
 3. Thrombocytopenia, as described under the criteria of 107.06 or 7.06.

or

- H. Neurological manifestations of HIV infection (e.g., HIV encephalopathy, peripheral neuropathy), as described under the criteria in 111.00ff, or resulting in one or more of the following:

1. Loss of previously acquired, or marked delay in achieving, developmental milestones or intellectual ability (including the sudden acquisition of a new learning disability); or
2. Impaired brain growth (acquired microcephaly or brain atrophy—see 114.00D5); or
3. Progressive motor dysfunction affecting gait and station or fine and gross motor skills.

or

- I. Growth disturbance, with:
 1. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall of 15 percentiles from established growth curve (on standard growth charts) that persists for 2 months or longer; or
 2. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall to below the third percentile from established growth curve (on standard growth charts) that persists for 2 months or longer; or
 3. Involuntary weight loss greater than 10 percent of baseline that persists for 2 months or longer; or
 4. Growth impairment as described under the criteria in 100.00ff.

or

- J. Diarrhea, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding.

or

- K. Cardiomyopathy, as described under the criteria in 104.00ff or 11.04.

or

- L. Lymphoid interstitial pneumonia/pulmonary lymphoid hyperplasia (LIP/PLH complex), with respiratory symptoms that significantly interfere with age-appropriate activities, and that cannot be controlled by prescribed treatment.

or

Social Security Administration

M. Nephropathy, as described under the criteria in 106.00.

or

- N. One or more of the following infections (other than described in A-M, above), resistant to treatment or requiring hospitalization or intravenous treatment 3 or more times in 1 year (or evaluate sequelae under the criteria for the affected body system):

1. Sepsis;
2. Meningitis; or
3. Pneumonia; or
4. Septic arthritis; or
5. Endocarditis; or
6. Radiographically documented sinusitis.

or

- O. Any other manifestation(s) of HIV infection (including any listed in 114.08A-N, but without the requisite findings, e.g., oral candidiasis not meeting the criteria in 114.08F, diarrhea not meeting the criteria in 114.08J, or any other manifestation(s), e.g., oral hairy leukoplakia, hepatomegaly), resulting in one of the following:

1. For children from birth to attainment of age 1, at least one of the criteria in paragraphs A-E of 112.12; or
2. For children age 1 to attainment of age 3, at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or
3. For children age 3 to attainment of age 18, at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

[50 FR 35066, Aug. 28, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting appendix 1 to subpart P of part 404, see the List of CFR Sections Affected in the Finding Aids section of this volume.

APPENDIX 2 TO SUBPART P—MEDICAL-VOCATIONAL GUIDELINES

Sec.

- 200.00 Introduction.
- 201.00 Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s).
- 202.00 Maximum sustained work capability limited to light work as a result of severe medically determinable impairment(s).
- 203.00 Maximum sustained work capability limited to medium work as a result of severe medically determinable impairment(s).
- 204.00 Maximum sustained work capability limited to heavy work (or very heavy work) as a result of severe medically determinable impairment(s).
- 200.00 Introduction. (a) The following rules reflect the major functional and vocational patterns which are encountered in cases which cannot be evaluated on medical con-

siderations alone, where an individual with a severe medically determinable physical or mental impairment(s) is not engaging in substantial gainful activity and the individual's impairment(s) prevents the performance of his or her vocationally relevant past work. They also reflect the analysis of the various vocational factors (i.e., age, education, and work experience) in combination with the individual's residual functional capacity (used to determine his or her maximum sustained work capability for sedentary, light, medium, heavy, or very heavy work) in evaluating the individual's ability to engage in substantial gainful activity in other than his or her vocationally relevant past work. Where the findings of fact made with respect to a particular individual's vocational factors and residual functional capacity coincide with all of the criteria of a particular rule, the rule directs a conclusion as to whether the individual is or is not disabled. However, each of these findings of fact is subject to rebuttal and the individual may present evidence to refute such findings. Where any one of the findings of fact does not coincide with the corresponding criterion of a rule, the rule does not apply in that particular case and, accordingly, does not direct a conclusion of disabled or not disabled. In any instance where a rule does not apply, full consideration must be given to all of the relevant facts of the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations.

(b) The existence of jobs in the national economy is reflected in the "Decisions" shown in the rules; i.e., in promulgating the rules, administrative notice has been taken of the numbers of unskilled jobs that exist throughout the national economy at the various functional levels (sedentary, light, medium, heavy, and very heavy) as supported by the "Dictionary of Occupational Titles," published by the Department of Labor; the "County Business Patterns" and "Census Surveys" published by the Bureau of the Census; and occupational surveys of light and sedentary jobs prepared for the Social Security Administration by various State employment agencies. Thus, when all factors coincide with the criteria of a rule, the existence of such jobs is established. However, the existence of such jobs for individuals whose remaining functional capacity or other factors do not coincide with the criteria of a rule must be further considered in terms of what kinds of jobs or types of work may be either additionally indicated or precluded.

(c) In the application of the rules, the individual's residual functional capacity (i.e., the maximum degree to which the individual retains the capacity for sustained performance of the physical-mental requirements of jobs), age, education, and work experience

must first be determined. When assessing the person's residual functional capacity, we consider his or her symptoms (such as pain), signs, and laboratory findings together with other evidence we obtain.

(d) The correct disability decision (i.e., on the issue of ability to engage in substantial gainful activity) is found by then locating the individual's specific vocational profile. If an individual's specific profile is not listed within this appendix 2, a conclusion of disabled or not disabled is not directed. Thus, for example, an individual's ability to engage in substantial gainful work where his or her residual functional capacity falls between the ranges of work indicated in the rules (e.g., the individual who can perform more than light but less than medium work), is decided on the basis of the principles and definitions in the regulations, giving consideration to the rules for specific case situations in this appendix 2. These rules represent various combinations of exertional capabilities, age, education and work experience and also provide an overall structure for evaluation of those cases in which the judgments as to each factor do not coincide with those of any specific rule. Thus, when the necessary judgments have been made as to each factor and it is found that no specific rule applies, the rules still provide guidance for decisionmaking, such as in cases involving combinations of impairments. For example, if strength limitations resulting from an individual's impairment(s) considered with the judgments made as to the individual's age, education and work experience correspond to (or closely approximate) the factors of a particular rule, the adjudicator then has a frame of reference for considering the jobs or types of work precluded by other, nonexertional impairments in terms of numbers of jobs remaining for a particular individual.

(e) Since the rules are predicated on an individual's having an impairment which manifests itself by limitations in meeting the strength requirements of jobs, they may not be fully applicable where the nature of an individual's impairment does not result in such limitations, e.g., certain mental, sensory, or skin impairments. In addition, some impairments may result solely in postural and manipulative limitations or environmental restrictions. Environmental restrictions are those restrictions which result in inability to tolerate some physical feature(s) of work settings that occur in certain industries or types of work, e.g., an inability to tolerate dust or fumes.

(1) In the evaluation of disability where the individual has solely a nonexertional type of impairment, determination as to whether disability exists shall be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in this ap-

pendix 2. The rules do not direct factual conclusions of disabled or not disabled for individuals with solely nonexertional types of impairments.

(2) However, where an individual has an impairment or combination of impairments resulting in both strength limitations and nonexertional limitations, the rules in this subpart are considered in determining first whether a finding of disabled may be possible based on the strength limitations alone and, if not, the rule(s) reflecting the individual's maximum residual strength capabilities, age, education, and work experience provide a framework for consideration of how much the individual's work capability is further diminished in terms of any types of jobs that would be contraindicated by the nonexertional limitations. Also, in these combinations of nonexertional and exertional limitations which cannot be wholly determined under the rules in this appendix 2, full consideration must be given to all of the relevant facts in the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations, which will provide insight into the adjudicative weight to be accorded each factor.

201.00 Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s). (a) Most sedentary occupations fall within the skilled, semi-skilled, professional, administrative, technical, clerical, and benchwork classifications. Approximately 200 separate unskilled sedentary occupations can be identified, each representing numerous jobs in the national economy. Approximately 85 percent of these jobs are in the machine trades and benchwork occupational categories. These jobs (unskilled sedentary occupations) may be performed after a short demonstration or within 30 days.

(b) These unskilled sedentary occupations are standard within the industries in which they exist. While sedentary work represents a significantly restricted range of work, this range in itself is not so prohibitively restricted as to negate work capability for substantial gainful activity.

(c) Vocational adjustment to sedentary work may be expected where the individual has special skills or experience relevant to sedentary work or where age and basic educational competences provide sufficient occupational mobility to adapt to the major segment of unskilled sedentary work. Inability to engage in substantial gainful activity would be indicated where an individual who is restricted to sedentary work because of a severe medically determinable impairment lacks special skills or experience relevant to sedentary work, lacks educational qualifications relevant to most sedentary work (e.g.,

has a limited education or less) and the individual's age, though not necessarily advanced, is a factor which significantly limits vocational adaptability.

(d) The adversity of functional restrictions to sedentary work at advanced age (55 and over) for individuals with no relevant past work or who can no longer perform vocationally relevant past work and have no transferable skills, warrants a finding of disabled in the absence of the rare situation where the individual has recently completed education which provides a basis for direct entry into skilled sedentary work. Advanced age and a history of unskilled work or no work experience would ordinarily offset any vocational advantages that might accrue by reason of any remote past education, whether it is more or less than limited education.

(e) The presence of acquired skills that are readily transferable to a significant range of skilled work within an individual's residual functional capacity would ordinarily warrant a finding of ability to engage in substantial gainful activity regardless of the adversity of age, or whether the individual's formal education is commensurate with his or her demonstrated skill level. The acquisition of work skills demonstrates the ability to perform work at the level of complexity demonstrated by the skill level attained regardless of the individual's formal educational attainments.

(f) In order to find transferability of skills to skilled sedentary work for individuals who are of advanced age (55 and over), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry.

(g) Individuals approaching advanced age (age 50-54) may be significantly limited in vocational adaptability if they are restricted to sedentary work. When such individuals have no past work experience or can no longer perform vocationally relevant past work and have no transferable skills, a finding of disabled ordinarily obtains. However, recently completed education which provides for direct entry into sedentary work will preclude such a finding. For this age group, even a high school education or more (ordinarily completed in the remote past) would have little impact for effecting a vocational adjustment unless relevant work experience reflects use of such education.

(h) The term *younger individual* is used to denote an individual age 18 through 49. For those within this group who are age 45-49, age is a less positive factor than for those who are age 18-44. Accordingly, for such individuals: (1) who are restricted to sedentary work, (2) who are unskilled or have no transferable skills, (3) who have no relevant past work or who can no longer perform vocationally relevant past work, and (4) who are either illiterate or unable to communicate in

the English language, a finding of disabled is warranted. On the other hand, age is a more positive factor for those who are under age 45 and is usually not a significant factor in limiting such an individual's ability to make a vocational adjustment, even an adjustment to unskilled sedentary work, and even where the individual is illiterate or unable to communicate in English. However, a finding of disabled is not precluded for those individuals under age 45 who do not meet all of the criteria of a specific rule and who do not have the ability to perform a full range of sedentary work. The following examples are illustrative: Example 1: An individual under age 45 with a high school education can no longer do past work and is restricted to unskilled sedentary jobs because of a severe medically determinable cardiovascular impairment (which does not meet or equal the listings in appendix 1). A permanent injury of the right hand limits the individual to sedentary jobs which do not require bilateral manual dexterity. None of the rules in appendix 2 are applicable to this particular set of facts, because this individual cannot perform the full range of work defined as sedentary. Since the inability to perform jobs requiring bilateral manual dexterity significantly compromises the only range of work for which the individual is otherwise qualified (i.e., sedentary), a finding of disabled would be appropriate. Example 2: An illiterate 41 year old individual with mild mental retardation (IQ of 78) is restricted to unskilled sedentary work and cannot perform vocationally relevant past work, which had consisted of unskilled agricultural field work; his or her particular characteristics do not specifically meet any of the rules in appendix 2, because this individual cannot perform the full range of work defined as sedentary. In light of the adverse factors which further narrow the range of sedentary work for which this individual is qualified, a finding of disabled is appropriate.

(i) While illiteracy or the inability to communicate in English may significantly limit an individual's vocational scope, the primary work functions in the bulk of unskilled work relate to working with things (rather than with data or people) and in these work functions at the unskilled level, literacy or ability to communicate in English has the least significance. Similarly the lack of relevant work experience would have little significance since the bulk of unskilled jobs require no qualifying work experience. Thus, the functional capability for a full range of sedentary work represents sufficient numbers of jobs to indicate substantial vocational scope for those individuals age 18-44 even if they are illiterate or unable to communicate in English.

TABLE NO. 1—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO SEDENTARY WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
201.01	Advanced age	Limited or less	Unskilled or none	Disabled.
201.02	do	do	Skilled or semiskilled—skills not transferable ¹ .	Do.
201.03	do	do	Skilled or semiskilled—skills transferable ¹ .	Not disabled.
201.04	do	High school graduate or more—does not provide for direct entry into skilled work ² .	Unskilled or none	Disabled.
201.05	do	High school graduate or more—provides for direct entry into skilled work ² .	do	Not disabled.
201.06	do	High school graduate or more—does not provide for direct entry into skilled work ² .	Skilled or semiskilled—skills not transferable ¹ .	Disabled.
201.07	do	do	Skilled or semiskilled—skills transferable ¹ .	Not disabled.
201.08	do	High school graduate or more—provides for direct entry into skilled work ² .	Skilled or semiskilled—skills not transferable ¹ .	Do.
201.09	Closely approaching advanced age.	Limited or less	Unskilled or none	Disabled.
201.10	do	do	Skilled or semiskilled—skills not transferable.	Do.
201.11	do	do	Skilled or semiskilled—skills transferable.	Not disabled.
201.12	do	High school graduate or more—does not provide for direct entry into skilled work ³ .	Unskilled or none	Disabled.
201.13	do	High school graduate or more—provides for direct entry into skilled work ³ .	do	Not disabled.
201.14	do	High school graduate or more—does not provide for direct entry into skilled work ³ .	Skilled or semiskilled—skills not transferable.	Disabled.
201.15	do	do	Skilled or semiskilled—skills transferable.	Not disabled.
201.16	do	High school graduate or more—provides for direct entry into skilled work ³ .	Skilled or semiskilled—skills not transferable.	Do.
201.17	Younger individual age 45-49.	Illiterate or unable to communicate in English.	Unskilled or none	Disabled.
201.18	do	Limited or less—at least literate and able to communicate in English.	do	Not disabled.
201.19	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
201.20	do	do	Skilled or semiskilled—skills transferable.	Do.
201.21	do	High school graduate or more	Skilled or semiskilled—skills not transferable.	Do.
201.22	do	do	Skilled or semiskilled—skills transferable.	Do.
201.23	Younger individual age 18-44.	Illiterate or unable to communicate in English.	Unskilled or none	Do. ⁴
201.24	do	Limited or less—at least literate and able to communicate in English.	do	Do. ⁴
201.25	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do. ⁴
201.26	do	do	Skilled or semiskilled—skills transferable.	Do. ⁴
201.27	do	High school graduate or more	Unskilled or none	Do. ⁴
201.28	do	do	Skilled or semiskilled—skills not transferable.	Do. ⁴

TABLE NO. 1—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO SEDENTARY WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
201.29	do	do	Skilled or semiskilled—skills transferable.	Do. ⁴

¹ See 201.00(f).² See 201.00(d).³ See 201.00(g).⁴ See 201.00(h).

202.00 *Maximum sustained work capability limited to light work as a result of severe medically determinable impairment(s).* (a) The functional capacity to perform a full range of light work includes the functional capacity to perform sedentary as well as light work. Approximately 1,600 separate sedentary and light unskilled occupations can be identified in eight broad occupational categories, each occupation representing numerous jobs in the national economy. These jobs can be performed after a short demonstration or within 30 days, and do not require special skills or experience.

(b) The functional capacity to perform a wide or full range of light work represents substantial work capability compatible with making a work adjustment to substantial numbers of unskilled jobs and, thus, generally provides sufficient occupational mobility even for severely impaired individuals who are not of advanced age and have sufficient educational competences for unskilled work.

(c) However, for individuals of advanced age who can no longer perform vocationally relevant past work and who have a history of unskilled work experience, or who have only skills that are not readily transferable to a significant range of semi-skilled or skilled work that is within the individual's functional capacity, or who have no work experience, the limitations in vocational adaptability represented by functional restriction to light work warrant a finding of disabled. Ordinarily, even a high school education or more which was completed in the remote past will have little positive impact on effecting a vocational adjustment unless relevant work experience reflects use of such education.

(d) Where the same factors in paragraph (c) of this section regarding education and work experience are present, but where age, though not advanced, is a factor which significantly

limits vocational adaptability (i.e., closely approaching advanced age, 50-54) and an individual's vocational scope is further significantly limited by illiteracy or inability to communicate in English, a finding of disabled is warranted.

(e) The presence of acquired skills that are readily transferable to a significant range of semi-skilled or skilled work within an individual's residual functional capacity would ordinarily warrant a finding of not disabled regardless of the adversity of age, or whether the individual's formal education is commensurate with his or her demonstrated skill level. The acquisition of work skills demonstrates the ability to perform work at the level of complexity demonstrated by the skill level attained regardless of the individual's formal educational attainments.

(f) For a finding of transferability of skills to light work for individuals of advanced age who are closely approaching retirement age (age 60-64), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry.

(g) While illiteracy or the inability to communicate in English may significantly limit an individual's vocational scope, the primary work functions in the bulk of unskilled work relate to working with things (rather than with data or people) and in these work functions at the unskilled level, literacy or ability to communicate in English has the least significance. Similarly, the lack of relevant work experience would have little significance since the bulk of unskilled jobs require no qualifying work experience. The capability for light work, which includes the ability to do sedentary work, represents the capability for substantial numbers of such jobs. This, in turn, represents substantial vocational scope for younger individuals (age 18-49) even if illiterate or unable to communicate in English.

TABLE NO. 2—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO LIGHT WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
202.01	Advanced age	Limited or less	Unskilled or none	Disabled.

TABLE NO. 2—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO LIGHT WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
202.02	do	do	Skilled or semiskilled—skills not transferable.	Do.
202.03	do	do	Skilled or semiskilled—skills transferable ¹ .	Not disabled.
202.04	do	High school graduate or more—does not provide for direct entry into skilled work ² .	Unskilled or none	Disabled.
202.05	do	High school graduate or more—provides for direct entry into skilled work ² .	do	Not disabled.
202.06	do	High school graduate or more—does not provide for direct entry into skilled work ² .	Skilled or semiskilled—skills not transferable.	Disabled.
202.07	do	do	Skilled or semiskilled—skills transferable ² .	Not disabled.
202.08	do	High school graduate or more—provides for direct entry into skilled work ² .	Skilled or semiskilled—skills not transferable.	Do.
202.09	Closely approaching advanced age.	Illiterate or unable to communicate in English.	Unskilled or none	Disabled.
202.10	do	Limited or less—at least literate and able to communicate in English.	do	Not disabled.
202.11	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
202.12	do	do	Skilled or semiskilled—skills transferable.	Do.
202.13	do	High school graduate or more	Unskilled or none	Do.
202.14	do	do	Skilled or semiskilled—skills not transferable.	Do.
202.15	do	do	Skilled or semiskilled—skills transferable.	Do.
202.16	Younger individual	Illiterate or unable to communicate in English.	Unskilled or none	Do.
202.17	do	Limited or less—at least literate and able to communicate in English.	do	Do.
202.18	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
202.19	do	do	Skilled or semiskilled—skills transferable.	Do.
202.20	do	High school graduate or more	Unskilled or none	Do.
202.21	do	do	Skilled or semiskilled—skills not transferable.	Do.
202.22	do	do	Skilled or semiskilled—skills transferable.	Do.

¹ See 202.00(f).² See 202.00(c).

203.00 *Maximum sustained work capability limited to medium work as a result of severe medically determinable impairment(s).* (a) The functional capacity to perform medium work includes the functional capacity to perform sedentary, light, and medium work. Approximately 2,500 separate sedentary, light, and medium occupations can be identified, each occupation representing numerous jobs in the national economy which do not require skills or previous experience and which can be performed after a short demonstration or within 30 days.

(b) The functional capacity to perform medium work represents such substantial work

capability at even the unskilled level that a finding of disabled is ordinarily not warranted in cases where a severely impaired individual retains the functional capacity to perform medium work. Even the adversity of advanced age (55 or over) and a work history of unskilled work may be offset by the substantial work capability represented by the functional capacity to perform medium work. However, an individual with a marginal education and long work experience (i.e., 35 years or more) limited to the performance of arduous unskilled labor, who is not working and is no longer able to perform this labor because of a severe impairment(s),

may still be found disabled even though the individual is able to do medium work.

(c) However, the absence of any relevant work experience becomes a more significant adversity for individuals of advanced age (55 and over). Accordingly, this factor, in combination with a limited education or less,

militates against making a vocational adjustment to even this substantial range of work and a finding of disabled is appropriate. Further, for individuals closely approaching retirement age (60-64) with a work history of unskilled work and with marginal education or less, a finding of disabled is appropriate.

TABLE NO. 3—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO MEDIUM WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
203.01	Closely approaching retirement age.	Marginal or none	Unskilled or none	Disabled.
203.02	do	Limited or less	None	Do.
203.03	do	Limited	Unskilled	Not disabled.
203.04	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
203.05	do	do	Skilled or semiskilled—skills transferable.	Do.
203.06	do	High school graduate or more	Unskilled or none	Do.
203.07	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.08	do	do	Skilled or semiskilled—skills transferable.	Do.
203.09	do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.10	Advanced age	Limited or less	None	Disabled.
203.11	do	do	Unskilled	Not disabled.
203.12	do	do	Skilled or semiskilled—skills not transferable.	Do.
203.13	do	do	Skilled or semiskilled—skills transferable.	Do.
203.14	do	High school graduate or more	Unskilled or none	Do.
203.15	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.16	do	do	Skilled or semiskilled—skills transferable.	Do.
203.17	do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.18	Closely approaching advanced age.	Limited or less	Unskilled or none	Do.
203.19	do	do	Skilled or semiskilled—skills not transferable.	Do.
203.20	do	do	Skilled or semiskilled—skills transferable.	Do.
203.21	do	High school graduate or more	Unskilled or none	Do.
203.22	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.23	do	do	Skilled or semiskilled—skills transferable.	Do.
203.24	do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.25	Younger individual	Limited or less	Unskilled or none	Do.
203.26	do	do	Skilled or semiskilled—skills not transferable.	Do.
203.27	do	do	Skilled or semiskilled—skills transferable.	Do.
203.28	do	High school graduate or more	Unskilled or none	Do.
203.29	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.30	do	do	Skilled or semiskilled—skills transferable.	Do.

TABLE NO. 3—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO MEDIUM WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
203.31	do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.

204.00 *Maximum sustained work capability limited to heavy work (or very heavy work) as a result of severe medically determinable impairment(s).* The residual functional capacity to perform heavy work or very heavy work includes the functional capability for work at the lesser functional levels as well, and represents substantial work capability for jobs in the national economy at all skill and physical demand levels. Individuals who retain the functional capacity to perform heavy work (or very heavy work) ordinarily will not have a severe impairment or will be able to do their past work—either of which would have already provided a basis for a decision of “not disabled”. Environmental restrictions ordinarily would not significantly affect the range of work existing in the national economy for individuals with the physical capability for heavy work (or very heavy work). Thus an impairment which does not preclude heavy work (or very heavy work) would not ordinarily be the primary reason for unemployment, and generally is sufficient for a finding of not disabled, even though age, education, and skill level of prior work experience may be considered adverse.

[46 FR 55584, Aug. 20, 1980, as amended at 56 FR 57944, Nov. 14, 1991]

Subpart Q—Determinations of Disability

AUTHORITY: Secs. 205(a), 221, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 421, and 902(a)(5)).

SOURCE: 46 FR 29204, May 29, 1981, unless otherwise noted.

GENERAL PROVISIONS

§ 404.1601 Purpose and scope.

This subpart describes the standards of performance and administrative requirements and procedures for States making determinations of disability for the Secretary under title II of the Act. It also establishes the Secretary's responsibilities in carrying out the disability determination function.

(a) Sections 404.1601 through 404.1603 describe the purpose of the regulations

and the meaning of terms frequently used in the regulations. They also briefly set forth the responsibilities of the Secretary and the States covered in detail in other sections.

(b) Sections 404.1610 through 404.1618 describe the Secretary's and the State's responsibilities in performing the disability determination function.

(c) Sections 404.1620 through 404.1633 describe the administrative responsibilities and requirements.

(d) Sections 404.1634 through 404.1639 describe the level of performance below which the Secretary will consider a State agency to be substantially failing to make disability determinations consistent with the regulations and other written guidelines and the resulting action the Secretary will take.

(e) Sections 404.1640 through 404.1643 describe the rules for resolving disputes concerning fiscal issues and providing hearings when we propose to find that a State is in substantial failure.

(f) Sections 404.1644 through 404.1649 describe when and what action the Secretary will take and what action the State will be expected to take if the Secretary assumes the disability determination function from a State agency.

(g) Sections 404.1650 through 404.1653 describe the rules for resolving disputes concerning fiscal issues and providing hearings when we propose to find that a State is in substantial failure.

(h) Sections 404.1690 through 404.1694 describe when and what action the Secretary will take and what action the State will be expected to take if the Secretary assumes the disability determination function from a State agency.

(i) Sections 404.1690 through 404.1694 describe when and what action the Secretary will take and what action the State will be expected to take if the Secretary assumes the disability determination function from a State agency.

§ 404.1602 Definitions.

For purposes of this subpart:

Act means the Social Security Act, as amended.

Social Security Administration

Class or classes of cases means the categories into which disability claims are divided according to their characteristics.

Determination of disability or disability determination means one or more of the following decisions:

- Whether or not a person is under a disability;
- The date a person's disability began; or
- The date a person's disability ended.

Disability means *disability* or *blindness* as defined in sections 216(1) and 223 of the Act or as defined in title IV of the Federal Mine Safety and Health Act of 1977, as amended.

Disability determination function means making determinations as to disability and carrying out related administrative and other responsibilities.

Disability program means, as appropriate, the Federal programs for providing disability insurance benefits under title II of the Act and disability benefits under title IV of the Federal Mine Safety and Health Act of 1977, as amended.

Initial means the first level of disability adjudication.

Other written guidelines means written issuances such as Social Security Rulings and memoranda by the Commissioner of Social Security, the Deputy Commissioner for Programs, or the Associate Commissioner for Disability and the procedures, guides, and operating instructions in the Disability Insurance sections of the Program Operations Manual System, that are instructive, interpretive, clarifying, and/or administrative and not designated as advisory or discretionary. The purpose of including the foregoing material in the definition is to assure uniform national application of program standards and service delivery to the public.

Regulations means regulations in this subpart issued under sections 205(a), 221 and 1102 of the Act, unless otherwise indicated.

Secretary means the Secretary of the Department of Health and Human Services or the Secretary's delegate.

State means any of the 50 States of the United States, the Commonwealth of Puerto Rico, the District of Colum-

bia, or Guam. It includes the State agency.

State agency means that agency of a State which has been designated by the State to carry out the disability determination function.

We, us, and our refers to the Social Security Administration (SSA) or the Secretary, as appropriate.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11018, Mar. 14, 1991]

§ 404.1603 Basic responsibilities for us and the State.

(a) *General.* We will work with the State to provide and maintain an effective system for processing claims of those who apply for and who are receiving benefits under the disability program. We will provide program standards, leadership, and oversight. We do not intend to become involved in the State's ongoing management of the program except as is necessary and in accordance with these regulations. The State will comply with our regulations and other written guidelines.

(b) *Our responsibilities.* We will:

(1) Periodically review the regulations and other written guidelines to determine whether they insure effective and uniform administration of the disability program. To the extent feasible, we will consult with and take into consideration the experience of the States in issuing regulations and guidelines necessary to insure effective and uniform administration of the disability program;

(2) Provide training materials or in some instances conduct or specify training, see § 404.1622;

(3) Provide funds to the State agency for the necessary cost of performing the disability determination function, see § 404.1626;

(4) Monitor and evaluate the performance of the State agency under the established standards, see §§ 404.1644 and 404.1645; and

(5) Maintain liaison with the medical profession nationally and with national organizations and agencies whose interests or activities may affect the disability program.

(c) *Responsibilities of the State.* The State will:

(1) Provide management needed to insure that the State agency carries

TABLE NO. 3—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO MEDIUM WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
203.31	do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.

204.00 *Maximum sustained work capability limited to heavy work (or very heavy work) as a result of severe medically determinable impairment(s).* The residual functional capacity to perform heavy work or very heavy work includes the functional capability for work at the lesser functional levels as well, and represents substantial work capability for jobs in the national economy at all skill and physical demand levels. Individuals who retain the functional capacity to perform heavy work (or very heavy work) ordinarily will not have a severe impairment or will be able to do their past work—either of which would have already provided a basis for a decision of "not disabled". Environmental restrictions ordinarily would not significantly affect the range of work existing in the national economy for individuals with the physical capability for heavy work (or very heavy work). Thus an impairment which does not preclude heavy work (or very heavy work) would not ordinarily be the primary reason for unemployment, and generally is sufficient for a finding of not disabled, even though age, education, and skill level of prior work experience may be considered adverse.

[45 FR 55584, Aug. 20, 1980, as amended at 56 FR 57944, Nov. 14, 1991]

Subpart Q—Determinations of Disability

AUTHORITY: Secs. 205(a), 221, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 421, and 902(a)(5)).

SOURCE: 46 FR 29204, May 29, 1981, unless otherwise noted.

GENERAL PROVISIONS

§404.1601 Purpose and scope.

This subpart describes the standards of performance and administrative requirements and procedures for States making determinations of disability for the Secretary under title II of the Act. It also establishes the Secretary's responsibilities in carrying out the disability determination function.

(a) Sections 404.1601 through 404.1603 describe the purpose of the regulations

and the meaning of terms frequently used in the regulations. They also briefly set forth the responsibilities of the Secretary and the States covered in detail in other sections.

(b) Sections 404.1610 through 404.1618 describe the Secretary's and the State's responsibilities in performing the disability determination function.

(c) Sections 404.1620 through 404.1633 describe the administrative responsibilities and requirements of the States. The corresponding role of the Secretary is also set out.

(d) Sections 404.1640 through 404.1650 describe the performance accuracy and processing time standards for measuring State agency performance.

(e) Sections 404.1660 through 404.1661 describe when and what kind of assistance the Secretary will provide State agencies to help them improve performance.

(f) Sections 404.1670 through 404.1675 describe the level of performance below which the Secretary will consider a State agency to be substantially failing to make disability determinations consistent with the regulations and other written guidelines and the resulting action the Secretary will take.

(g) Sections 404.1680 through 404.1683 describe the rules for resolving disputes concerning fiscal issues and providing hearings when we propose to find that a State is in substantial failure.

(h) Sections 404.1690 through 404.1694 describe when and what action the Secretary will take and what action the State will be expected to take if the Secretary assumes the disability determination function from a State agency.

§404.1602 Definitions.

For purposes of this subpart:

Act means the Social Security Act, as amended.

Social Security Administration

Class or classes of cases means the categories into which disability claims are divided according to their characteristics.

Determination of disability or disability determination means one or more of the following decisions:

(a) Whether or not a person is under a disability;

(b) The date a person's disability began; or

(c) The date a person's disability ended.

Disability means *disability* or *blindness* as defined in sections 216(1) and 223 of the Act or as defined in title IV of the Federal Mine Safety and Health Act of 1977, as amended.

Disability determination function means making determinations as to disability and carrying out related administrative and other responsibilities.

Disability program means, as appropriate, the Federal programs for providing disability insurance benefits under title II of the Act and disability benefits under title IV of the Federal Mine Safety and Health Act of 1977, as amended.

Initial means the first level of disability adjudication.

Other written guidelines means written issuances such as Social Security Rulings and memoranda by the Commissioner of Social Security, the Deputy Commissioner for Programs, or the Associate Commissioner for Disability and the procedures, guides, and operating instructions in the Disability Insurance sections of the Program Operations Manual System, that are instructive, interpretive, clarifying, and/or administrative and not designated as advisory or discretionary. The purpose of including the foregoing material in the definition is to assure uniform national application of program standards and service delivery to the public.

Regulations means regulations in this subpart issued under sections 205(a), 221 and 1102 of the Act, unless otherwise indicated.

Secretary means the Secretary of the Department of Health and Human Services or the Secretary's delegate.

State means any of the 50 States of the United States, the Commonwealth of Puerto Rico, the District of Colum-

bia, or Guam. It includes the State agency.

State agency means that agency of a State which has been designated by the State to carry out the disability determination function.

We, us, and our refers to the Social Security Administration (SSA) or the Secretary, as appropriate.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11018, Mar. 14, 1991]

§404.1603 Basic responsibilities for us and the State.

(a) *General.* We will work with the State to provide and maintain an effective system for processing claims of those who apply for and who are receiving benefits under the disability program. We will provide program standards, leadership, and oversight. We do not intend to become involved in the State's ongoing management of the program except as is necessary and in accordance with these regulations. The State will comply with our regulations and other written guidelines.

(b) *Our responsibilities.* We will:

(1) Periodically review the regulations and other written guidelines to determine whether they insure effective and uniform administration of the disability program. To the extent feasible, we will consult with and take into consideration the experience of the States in issuing regulations and guidelines necessary to insure effective and uniform administration of the disability program;

(2) Provide training materials or in some instances conduct or specify training, see §404.1622;

(3) Provide funds to the State agency for the necessary cost of performing the disability determination function, see §404.1626;

(4) Monitor and evaluate the performance of the State agency under the established standards, see §§404.1644 and 404.1645; and

(5) Maintain liaison with the medical profession nationally and with national organizations and agencies whose interests or activities may affect the disability program.

(c) *Responsibilities of the State.* The State will:

(1) Provide management needed to insure that the State agency carries

claim with the Social Security Administration which is pending or has been denied and who has also filed a part C claim with the Office of Workers' Compensation Programs, which has been approved, shall be entitled, upon request, to a review of the pending or denied part B claim in light of the BLBRA of 1977 by either the Social Security Administration or the Office of Workers' Compensation Programs, in accordance with this subpart.

(c) Pending or denied by the Social Security Administration and the Office of Workers' Compensation Programs. A person who has filed a claim both with the Social Security Administration and the Office of Workers' Compensation Programs and whose claims are either pending with or have been denied by both agencies shall have the claim reviewed under the BLBRA of 1977 by the Social Security Administration if such review is requested by the claimant. If the claim is not approved by the Social Security Administration it shall be forwarded to the Office of Workers' Compensation Programs for further review as provided in §410.704(e)(2). During the pendency of review proceedings by the Social Security Administration, if any, no action shall be taken by the Secretary of Labor with respect to the part C claim which is pending or has been denied by DOL. If the claimant does not respond to notification of his or her right to review by the Social Security Administration within 6 months of the notice (see §410.704(c)) unless the period is enlarged for good cause shown, the Office of Workers' Compensation Programs shall proceed under DOL's regulations at 20 CFR part 727 to review the claim originally filed with the Secretary of Labor. If the claimant, upon notification by the Social Security Administration of his or her right to review (see §410.704(a)) requests that the claim originally filed with the Social Security Administration be forwarded to the Office of Workers' Compensation Programs for review, or if more than one claim has been filed with the Secretary of Labor by the same claimant, such claims shall be merged and processed with the first claim filed with the Office of Workers' Compensation Programs.

§410.706 Effect of the Social Security Administration determination of entitlement.

Under section 435 of the BLBRA of 1977 a determination of entitlement made by the Social Security Administration under this subpart G is binding on the Office of Workers' Compensation Programs as an initial determination of eligibility.

§410.707 Hearings and appeals.

The review of any determination made by the Social Security Administration of a claim under this subpart will be made by the Office of Workers' Compensation Programs. If the Social Security Administration does not approve the claim following its review under this subpart, the claim will be referred to the Office of Worker's Compensation Programs, and the Office of Workers' Compensation Programs will automatically review the claim. The Office of Workers' Compensation Programs will provide an opportunity for the claimant to submit additional evidence if it is needed to approve the claim. See §410.704(e)(2) of this subpart. If the Social Security Administration approves the claim but the claimant disagrees with any part of the Social Security Administration's determination, he or she may request the Office of Workers' Compensation Programs to review the Social Security Administration's determination. See §410.704 (e)(1) of this subpart.

PART 416—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

Subpart A—Introduction, General Provisions and Definitions

Sec.

- 416.101 Introduction.
- 416.105 Administration.
- 416.110 Purpose of program.
- 416.120 General definitions and use of terms.
- 416.121 Receipt of aid or assistance for December 1973 under an approved State plan under title I, X, XIV, or XVI of the Social Security Act.

Subpart B—Eligibility

GENERAL

- 416.200 Introduction.
- 416.201 General definitions and terms used in this subpart.
- 416.202 Who may get SSI benefits.
- 416.203 Initial determinations of SSI eligibility.
- 416.204 Redeterminations of SSI eligibility.

REASONS WHY YOU MAY NOT GET SSI BENEFITS FOR WHICH YOU ARE OTHERWISE ELIGIBLE

- 416.210 You do not apply for other benefits.
- 416.211 You are a resident of a public institution.
- 416.212 Continuation of full benefits in certain cases of medical confinement.
- 416.213 You do not accept vocational rehabilitation services.
- 416.214 You are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability.
- 416.215 You leave the United States.
- 416.216 You are a child of armed forces personnel living overseas.

ELIGIBILITY FOR INCREASED BENEFITS BECAUSE OF ESSENTIAL PERSONS

- 416.220 General.
- 416.221 Who is a qualified individual.
- 416.222 Who is an essential person.
- 416.223 What happens if you are a qualified individual.
- 416.250 Experimental, pilot, and demonstration projects in the SSI program.

SPECIAL PROVISIONS FOR PEOPLE WHO WORK DESPITE A DISABLING IMPAIRMENT

- 416.260 General.
- 416.261 What are special SSI cash benefits and when are they payable.
- 416.262 Eligibility requirements for special SSI cash benefits.
- 416.263 No additional application needed.
- 416.264 When does the "special SSI eligibility status" apply.
- 416.265 Requirements for the special SSI eligibility status.
- 416.266 Continuation of SSI status for Medicaid.
- 416.267 General.
- 416.268 What is done to determine if you must have Medicaid in order to work.
- 416.269 What is done to determine whether your earnings are too low to provide comparable benefits and services you would receive in the absence of those earnings.

Subpart C—Filing of Applications

GENERAL PROVISIONS

- 416.301 Introduction.
- 416.302 Definitions.
- 416.305 You must file an application to receive supplemental security income benefits.

APPLICATIONS

- 416.310 What makes an application a claim for benefits.
- 416.315 Who may sign an application.
- 416.320 Evidence of authority to sign an application for another.
- 416.325 When an application is considered filed.

EFFECTIVE FILING PERIOD OF APPLICATION

- 416.330 Filing before the first month you meet the requirements for eligibility.
- 416.335 Filing in or after the month you meet the requirements for eligibility.

FILING DATE BASED UPON A WRITTEN STATEMENT OR ORAL INQUIRY

- 416.340 Use of date of written statement as application filing date.
- 416.345 Use of date of oral inquiry as application filing date.
- 416.350 Treating a title II application as an oral inquiry about SSI benefits.

DEEMED FILING DATE BASED ON MISINFORMATION

- 416.351 Deemed filing date in a case of misinformation.

WITHDRAWAL OF APPLICATION

- 416.355 Withdrawal of an application.
- 416.360 Cancellation of a request to withdraw.

Subpart D—Amount of Benefits

- 416.401 Scope of subpart.
- 416.405 Cost-of-living adjustments in benefits.
- 416.410 Amount of benefits; eligible individual.
- 416.412 Amount of benefits; eligible couple.
- 416.413 Amount of benefits; qualified individual.
- 416.414 Amount of benefits; eligible individual or eligible couple for a medical care facility.
- 416.415 Amount of benefits; eligible individual is disabled child under age 18.
- 416.420 Determination of benefits; general.
- 416.421 Determination of benefits; computation of prorated benefits.
- 416.426 Change in status involving an individual; ineligibility occurs.

- 416.428 Eligible individual without an eligible spouse has an essential person in his home.
- 416.430 Eligible individual with eligible spouse; essential person(s) present.
- 416.432 Change in status involving a couple; eligibility continues.
- 416.435 Change in status involving a couple; ineligibility occurs.

Subpart E—Payment of Benefits, Overpayments, and Underpayments

- 416.501 Payment of benefits: General.
- 416.502 Manner of payment.
- 416.503 Minimum monthly benefit amount.
- 416.520 Emergency advance payments.
- 416.525 Reimbursement to States for interim assistance payments.
- 416.532 Method of payment when the essential person resides with more than one eligible person.
- 416.533 Transfer or assignment of benefits.
- 416.535 Underpayments and overpayments.
- 416.536 Underpayments—defined.
- 416.537 Overpayments—defined.
- 416.538 Amount of underpayment or overpayment.
- 416.542 Underpayments—to whom underpaid amount is payable.
- 416.543 Underpayments—applied to reduce overpayments.
- 416.544 Paying benefit.
- 416.550 Waiver of adj when applicable.
- 416.551 Waiver of adj effect of.
- 416.552 Waiver of adj without fault.
- 416.553 Waiver of adj defeat the purpose security income pr
- 416.554 Waiver of adj against equity and
- 416.555 Waiver of adj impede administration.
- 416.556 Waiver of adjustment or recovery—countable resources in excess of the limits prescribed in §416.1205 by \$50 or less.
- 416.558 Notice relating to overpayments and underpayments.
- 416.560 Recovery—refund.
- 416.570 Adjustment—general rule.
- 416.571 10-percent limitation of recoupment rate—overpayment.

Subpart F—Representative Payment

- 416.601 Introduction.
- 416.610 When payment will be made to a representative payee.
- 416.615 Information considered in determining whether to make representative payment.
- 416.620 Information considered in selecting a representative payee.

- 416.621 Order of preference in selecting a representative payee.
- 416.625 Information to be submitted by a representative payee.
- 416.630 Advance notice of the determination to make representative payment.
- 416.635 Responsibilities of a representative payee.
- 416.640 Use of benefit payments.
- 416.640a Compensation for qualified organizations serving as representative payees.
- 416.641 Liability for misuse of benefit payments.
- 416.645 Conservation and investment of benefit payments.
- 416.650 When new representative payee will be selected.
- 416.655 When representative payment will be stopped.
- 416.660 Transfer of accumulated benefit payments.
- 416.665 Accounting for benefit payments.

Subpart G—Reports Required

INTRODUCTION

- 416.701 Scope of subpart.
- 416.702 Definitions.

REPORT PROVISIONS

- st make reports.
- u must report.
- ports must include.
- f the report.
- ports are due.

PENALTY DEDUCTIONS

- stances under which we make deduction.
- ts of penalty deductions.
- y period: First failure to re-
- y period: Second failure to re-

- 416.730 Penalty period: Three or more failures to report.
- 416.732 No penalty deduction if you have good cause for failure to report timely.

Subpart H—Determination of Age

- 416.801 Evidence as to age—when required.
- 416.802 Type of evidence to be submitted.
- 416.803 Evaluation of evidence.
- 416.804 Certified copy in lieu of original.
- 416.805 When additional evidence may be required.
- 416.806 Expedited adjudication based on documentary evidence of age.

Subpart I—Determining Disability and Blindness

GENERAL

- 416.901 Scope of subpart.
- 416.902 General definitions and terms for this subpart.

DETERMINATIONS

- 416.903 Who makes disability and blindness determinations.
- 416.903a Program integrity.
- 416.904 Determinations by other organizations and agencies.

DEFINITION OF DISABILITY

- 416.905 Basic definition of disability for adults.
- 416.906 Basic definition of disability for children.
- 416.907 Disability under a State plan.
- 416.908 What is needed to show an impairment.
- 416.909 How long the impairment must last.
- 416.910 Meaning of substantial gainful activity.
- 416.911 Definition of disabling impairment.

EVIDENCE

- 416.912 Evidence of your impairment.
- 416.913 Medical evidence of your impairment.
- 416.914 When we will purchase existing evidence.
- 416.915 Where and how to submit evidence.
- 416.916 If you fail to submit medical and other evidence.
- 416.917 Consultative examination at our expense.
- 416.918 If you do not appear at a consult-

STA
W
B
IT

416.
416.

416.
416.

416.
416.

ST

- 416.919f Type of purchased examinations.
- 416.919g Who we will select to perform a consultative examination.
- 416.919h Your treating physician or psychologist.
- 416.919i Other sources for consultative examinations.
- 416.919j Objections to the designated physician or psychologist.

- 416.919k Purchase of medical examinations, laboratory tests, and other services.
- 416.919m Diagnostic tests or procedures.
- 416.919n Informing the examining physician or psychologist of examination scheduling, report content, and signature requirements.
- 416.919o When a properly signed consultative examination report has not been received.
- 416.919p Reviewing reports of consultative examinations.
- 416.919q Conflict of interest.

AUTHORIZING AND MONITORING THE REFERRAL PROCESS

- 416.919s Authorizing and monitoring the consultative examination.

PROCEDURES TO MONITOR THE CONSULTATIVE EXAMINATION

- 416.919t Consultative examination oversight.

EVALUATION OF DISABILITY

- 416.920 Evaluation of disability of adults, in general.
- 416.920a Evaluation of mental impairments.
- 416.921 What we mean by a not severe impairment(s) in an adult.
- 416.922 When you have two or more unrelated impairments—initial claims.
- 416.923 Multiple impairments.
- 416.924 How we determine disability for children.
- 416.924a Age as a factor of evaluation in childhood disability.
- 416.924b Functioning in children.
- 416.924c Other factors we will consider.
- 416.924d Individualized functional assessment for children.
- 416.924e Guidelines for determining disability using the individualized functional assessment.

MEDICAL CONSIDERATIONS

- 416.925 Listing of Impairments in Appendix 1 of Subpart P of Part 404 of this chapter.
- 416.926 Medical equivalence for adults.
- 416.926a Equivalence for children.
- 416.927 Evaluating medical opinions about your impairment(s) or disability.
- 416.928 Symptoms, signs, and laboratory findings.
- 416.929 How we evaluate symptoms, including pain.
- 416.930 Need to follow prescribed treatment.

PRESUMPTIVE DISABILITY AND BLINDNESS

- 416.931 The meaning of presumptive disability or presumptive blindness.
- 416.932 When presumptive payments begin and end.
- 416.933 How we make a finding of presumptive disability or presumptive blindness.

The highlighted sections are the ones copied for this package

These are the two specific regulations which are eliminated. The ones that remain are also important.

- 416.428 Eligible individual without an eligible spouse has an essential person in his home.
- 416.430 Eligible individual with eligible spouse; essential person(s) present.
- 416.432 Change in status involving a couple; eligibility continues.
- 416.435 Change in status involving a couple; ineligibility occurs.

Subpart E—Payment of Benefits, Overpayments, and Underpayments

- 416.501 Payment of benefits: General.
- 416.502 Manner of payment.
- 416.503 Minimum monthly benefit amount.
- 416.520 Emergency advance payments.
- 416.525 Reimbursement to States for interim assistance payments.
- 416.532 Method of payment when the essential person resides with more than one eligible person.
- 416.533 Transfer or assignment of benefits.
- 416.535 Underpayments and overpayments.
- 416.536 Underpayments—defined.
- 416.537 Overpayments—defined.
- 416.538 Amount of underpayment or overpayment.
- 416.542 Underpayments—to whom underpaid amount is payable.
- 416.543 Underpayments—applied to reduce overpayments.
- 416.544 Paying benefits in installments: Drug addiction or alcoholism.
- 416.550 Waiver of adjustment or recovery—when applicable.
- 416.551 Waiver of adjustment or recovery—effect of.
- 416.552 Waiver of adjustment or recovery—without fault.
- 416.553 Waiver of adjustment or recovery—defeat the purpose of the supplemental security income program.
- 416.554 Waiver of adjustment or recovery—against equity and good conscience.
- 416.555 Waiver of adjustment or recovery—impede administration.
- 416.556 Waiver of adjustment or recovery—countable resources in excess of the limits prescribed in § 416.1205 by \$50 or less.
- 416.558 Notice relating to overpayments and underpayments.
- 416.560 Recovery—refund.
- 416.570 Adjustment—general rule.
- 416.571 10-percent limitation of recoupment rate—overpayment.

Subpart F—Representative Payment

- 416.601 Introduction.
- 416.610 When payment will be made to a representative payee.
- 416.615 Information considered in determining whether to make representative payment.
- 416.620 Information considered in selecting a representative payee.

- 416.621 Order of preference in selecting a representative payee.
- 416.625 Information to be submitted by a representative payee.
- 416.630 Advance notice of the determination to make representative payment.
- 416.635 Responsibilities of a representative payee.
- 416.640 Use of benefit payments.
- 416.640a Compensation for qualified organizations serving as representative payees.
- 416.641 Liability for misuse of benefit payments.
- 416.645 Conservation and investment of benefit payments.
- 416.650 When new representative payee will be selected.
- 416.655 When representative payment will be stopped.
- 416.660 Transfer of accumulated benefit payments.
- 416.665 Accounting for benefit payments.

Subpart G—Reports Required

INTRODUCTION

- 416.701 Scope of subpart.
- 416.702 Definitions.

REPORT PROVISIONS

- 416.704 Who must make reports.
- 416.708 What you must report.
- 416.710 What reports must include.
- 416.712 Form of the report.
- 416.714 When reports are due.

PENALTY DEDUCTIONS

- 416.722 Circumstances under which we make a penalty deduction.
- 416.724 Amounts of penalty deductions.
- 416.726 Penalty period: First failure to report.
- 416.728 Penalty period: Second failure to report.
- 416.730 Penalty period: Three or more failures to report.
- 416.732 No penalty deduction if you have good cause for failure to report timely.

Subpart H—Determination of Age

- 416.801 Evidence as to age—when required.
- 416.802 Type of evidence to be submitted.
- 416.803 Evaluation of evidence.
- 416.804 Certified copy in lieu of original.
- 416.805 When additional evidence may be required.
- 416.806 Expedited adjudication based on documentary evidence of age.

Subpart I—Determining Disability and Blindness

GENERAL

- 416.901 Scope of subpart.
- 416.902 General definitions and terms for this subpart.

DETERMINATIONS

- 416.903 Who makes disability and blindness determinations.
- 416.903a Program integrity.
- 416.904 Determinations by other organizations and agencies.

DEFINITION OF DISABILITY

- 416.905 Basic definition of disability for adults.
- 416.906 Basic definition of disability for children.
- 416.907 Disability under a State plan.
- 416.908 What is needed to show an impairment.
- 416.909 How long the impairment must last.
- 416.910 Meaning of substantial gainful activity.
- 416.911 Definition of disabling impairment.

EVIDENCE

- 416.912 Evidence of your impairment.
- 416.913 Medical evidence of your impairment.
- 416.914 When we will purchase existing evidence.
- 416.915 Where and how to submit evidence.
- 416.916 If you fail to submit medical and other evidence.
- 416.917 Consultative examination at our expense.
- 416.918 If you do not appear at a consultative examination.

STANDARDS TO BE USED IN DETERMINING WHEN A CONSULTATIVE EXAMINATION WILL BE OBTAINED IN CONNECTION WITH DISABILITY DETERMINATIONS

- 416.919 The consultative examination.
- 416.919a When we will purchase a consultative examination and how we will use it.
- 416.919b When we will not purchase a consultative examination.

STANDARDS FOR THE TYPE OF REFERRAL AND FOR REPORT CONTENT

- 416.919f Type of purchased examinations.
- 416.919g Who we will select to perform a consultative examination.
- 416.919h Your treating physician or psychologist.
- 416.919i Other sources for consultative examinations.
- 416.919j Objections to the designated physician or psychologist.

- 416.919k Purchase of medical examinations, laboratory tests, and other services.
- 416.919m Diagnostic tests or procedures.
- 416.919n Informing the examining physician or psychologist of examination scheduling, report content, and signature requirements.
- 416.919o When a properly signed consultative examination report has not been received.
- 416.919p Reviewing reports of consultative examinations.
- 416.919q Conflict of interest.

AUTHORIZING AND MONITORING THE REFERRAL PROCESS

- 416.919s Authorizing and monitoring the consultative examination.

PROCEDURES TO MONITOR THE CONSULTATIVE EXAMINATION

- 416.919t Consultative examination oversight.

EVALUATION OF DISABILITY

- 416.920 Evaluation of disability of adults, in general.
- 416.920a Evaluation of mental impairments.
- 416.921 What we mean by a not severe impairment(s) in an adult.
- 416.922 When you have two or more unrelated impairments—initial claims.
- 416.923 Multiple impairments.
- 416.924 How we determine disability for children.
- 416.924a Age as a factor of evaluation in childhood disability.
- 416.924b Functioning in children.
- 416.924c Other factors we will consider.
- 416.924d Individualized functional assessment for children.
- 416.924e Guidelines for determining disability using the individualized functional assessment.

MEDICAL CONSIDERATIONS

- 416.925 Listing of Impairments in Appendix 1 of Subpart P of Part 404 of this chapter.
- 416.926 Medical equivalence for adults.
- 416.926a Equivalence for children.
- 416.927 Evaluating medical opinions about your impairment(s) or disability.
- 416.928 Symptoms, signs, and laboratory findings.
- 416.929 How we evaluate symptoms, including pain.
- 416.930 Need to follow prescribed treatment.

PRESUMPTIVE DISABILITY AND BLINDNESS

- 416.931 The meaning of presumptive disability or presumptive blindness.
- 416.932 When presumptive payments begin and end.
- 416.933 How we make a finding of presumptive disability or presumptive blindness.

416.934 Impairments which may warrant a finding of presumptive disability or presumptive blindness.

DRUG ADDICTION AND ALCOHOLISM

416.935 How we will determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

416.936 Treatment required for individuals whose drug addiction or alcoholism is a contributing factor material to the determination of disability.

416.937 What we mean by appropriate treatment.

416.938 What we mean by approved institutions or facilities.

416.939 How we consider whether treatment is available.

416.940 Evaluating compliance with the treatment requirements.

416.941 Establishment and use of referral and monitoring agencies.

RESIDUAL FUNCTIONAL CAPACITY

416.945 Your residual functional capacity.

416.946 Responsibility for assessing and determining residual functional capacity.

VOCATIONAL CONSIDERATIONS

416.960 When your vocational background will be considered.

416.961 Your ability to do work depends upon your residual functional capacity.

416.962 If you have done only arduous unskilled physical labor.

416.963 Your age as a vocational factor.

416.964 Your education as a vocational factor.

416.965 Your work experience as a vocational factor.

416.966 Work which exists in the national economy.

416.967 Physical exertion requirements.

416.968 Skill requirements.

416.969 Listing of Medical-Vocational Guidelines in Appendix 2 of Subpart P of Part 404 of this chapter.

416.969a Exertional and nonexertional limitations.

SUBSTANTIAL GAINFUL ACTIVITY

416.971 General.

416.972 What we mean by substantial gainful activity.

416.973 General information about work activity.

416.974 Evaluation guides if you are an employee.

416.975 Evaluation guides if you are self-employed.

416.976 Impairment-related work expenses.

416.981 Mean the law.

416.982 Blindness.

416.983 How necessary.

416.984 If you working.

416.985 How pairments.

416.986 Why and when we will find that you are no longer entitled to benefits based on statutory blindness.

CONTINUING OR STOPPING DISABILITY OR BLINDNESS

416.988 Your responsibility to tell us of events that may change your disability or blindness status.

416.989 We may conduct a review to find out whether you continue to be disabled.

416.989a We may conduct a review to find out whether you continue to be blind.

416.990 When and how often we will conduct a continuing disability review.

416.991 If your medical recovery was expected and you returned to work.

416.992 The trial work period.

416.992a The reentitlement period.

416.993 Medical evidence in continuing disability review cases.

416.994 How we will determine whether your disability continues or ends.

416.994a How we will determine whether your disability continues or ends, disabled children.

416.995 If we make a determination that your physical or mental impairment(s) has ceased, did not exist or is no longer disabling (Medical Cessation Determination).

416.996 Continued disability or blindness benefits pending appeal of a medical cessation determination.

416.998 If you become disabled by another impairment(s).

Subpart J—Determinations of Disability

GENERAL PROVISIONS

416.1001 Purpose and scope.

416.1002 Definitions.

416.1003 Basic responsibilities for us and the State.

RESPONSIBILITIES FOR PERFORMING THE DISABILITY DETERMINATION FUNCTION

416.1010 How a State notifies us that it wishes to perform the disability determination function.

416.1011 How we notify a State whether it may perform the disability determination function.

416.1013 Disability determinations the State makes.

Social Security Administration

416.1014 Responsibilities for obtaining evidence to make disability determinations.

416.1015 Making disability determinations.

416.1016 Medical or psychological consultant.

416.1017 Reasonable efforts to obtain review by a qualified psychiatrist or psychologist.

416.1018 Notifying claimants of the disability determination.

ADMINISTRATIVE RESPONSIBILITIES AND REQUIREMENTS

416.1020 General administrative requirements.

416.1021 Personnel.

416.1022 Training.

416.1023 Facilities.

416.1024 Medical and other purchased services.

416.1025 Records and reports.

416.1026 Fiscal.

416.1027 Audits.

416.1028 Property.

416.1029 Participation in research and demonstration projects.

416.1030 Coordination with other agencies.

416.1031 Confidentiality of information and records.

416.1032 Other Federal laws and regulations.

416.1033 Policies and operating instructions.

PERFORMANCE STANDARDS

416.1040 General.

416.1041 Standards of performance.

416.1042 Processing time standard.

416.1043 Performance accuracy standard.

416.1044 How and when we determine whether the processing time standards are met.

416.1045 How and when we determine whether the performance accuracy standard is met.

416.1050 Action we will take if a State agency does not meet the standards.

PERFORMANCE MONITORING AND SUPPORT

416.1060 How we will monitor.

416.1061 When we will provide performance support.

416.1062 What support we will provide.

SUBSTANTIAL FAILURE

416.1070 General.

416.1071 Good cause for not following the Act, our regulations, or other written guidelines.

416.1075 Finding of substantial failure.

HEARINGS AND APPEALS

416.1080 Notice of right to hearing on proposed finding of substantial failure.

416.1081 Disputes on matters other than substantial failure.

416.1082 Who conducts the hearings.

416.1083 Hearings and appeals process.

ASSUMPTION OF DISABILITY DETERMINATION FUNCTION

416.1090 Assumption when we make a finding of substantial failure.

416.1091 Assumption when State no longer wishes to perform the disability determination function.

416.1092 Protection of State employees.

416.1093 Limitation on State expenditures after notice.

416.1094 Final accounting by the State.

Subpart K—Income

GENERAL

416.1100 Income and SSI eligibility.

416.1101 Definition of terms.

416.1102 What is income.

416.1103 What is not income.

416.1104 Income we count.

EARNED INCOME

416.1110 What is earned income.

416.1111 How we count earned income.

416.1112 Earned income we do not count.

UNEARNED INCOME

416.1120 What is unearned income.

416.1121 Types of unearned income.

416.1123 How we count unearned income.

416.1124 Unearned income we do not count.

IN-KIND SUPPORT AND MAINTENANCE

416.1130 Introduction.

416.1131 The one-third reduction rule.

416.1132 What we mean by "living in another person's household."

416.1133 What is a pro rata share of household operating expenses.

416.1140 The presumed value rule.

416.1141 When the presumed value rule applies.

416.1142 If you live in a public assistance household.

416.1143 If you live in a noninstitutional care situation.

416.1144 If you live in a nonprofit retirement home or similar institution.

416.1145 How the presumed value rule applies in a nonmedical for-profit institution.

IN-KIND SUPPORT AND MAINTENANCE IN SPECIAL CIRCUMSTANCES

416.1147 How we value in-kind support and maintenance for a couple.

416.1147a Income rules in change-of-status situations involving in-kind support and maintenance.

416.1148 If you have both in-kind support and maintenance and income that is deemed to you.

416.934 Impairments which may warrant a finding of presumptive disability or presumptive blindness.

DRUG ADDICTION AND ALCOHOLISM

416.935 How we will determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

416.936 Treatment required for individuals whose drug addiction or alcoholism is a contributing factor material to the determination of disability.

416.937 What we mean by appropriate treatment.

416.938 What we mean by approved institutions or facilities.

416.939 How we consider whether treatment is available.

416.940 Evaluating compliance with the treatment requirements.

416.941 Establishment and use of referral and monitoring agencies.

RESIDUAL FUNCTIONAL CAPACITY

416.945 Your residual functional capacity.

416.946 Responsibility for assessing and determining residual functional capacity.

VOCATIONAL CONSIDERATIONS

416.960 When your vocational background will be considered.

416.961 Your ability to do work depends upon your residual functional capacity.

416.962 If you have done only arduous unskilled physical labor.

416.963 Your age as a vocational factor.

416.964 Your education as a vocational factor.

416.965 Your work experience as a vocational factor.

416.966 Work which exists in the national economy.

416.967 Physical exertion requirements.

416.968 Skill requirements.

416.969 Listing of Medical-Vocational Guidelines in Appendix 2 of Subpart P of Part 404 of this chapter.

416.969a Exertional and nonexertional limitations.

SUBSTANTIAL GAINFUL ACTIVITY

416.971 General.

416.972 What we mean by substantial gainful activity.

416.973 General information about work activity.

416.974 Evaluation guides if you are an employee.

416.975 Evaluation guides if you are self-employed.

416.976 Impairment-related work expenses.

BLINDNESS

416.981 Meaning of blindness as defined in the law.

416.982 Blindness under a State plan.

416.983 How we evaluate statutory blindness.

416.984 If you are statutorily blind and still working.

416.985 How we evaluate other visual impairments.

416.986 Why and when we will find that you are no longer entitled to benefits based on statutory blindness.

CONTINUING OR STOPPING DISABILITY OR BLINDNESS

416.988 Your responsibility to tell us of events that may change your disability or blindness status.

416.989 We may conduct a review to find out whether you continue to be disabled.

416.989a We may conduct a review to find out whether you continue to be blind.

416.990 When and how often we will conduct a continuing disability review.

416.991 If your medical recovery was expected and you returned to work.

416.992 The trial work period.

416.992a The reentitlement period.

416.993 Medical evidence in continuing disability review cases.

416.994 How we will determine whether your disability continues or ends.

416.994a How we will determine whether your disability continues or ends, disabled children.

416.995 If we make a determination that your physical or mental impairment(s) has ceased, did not exist or is no longer disabling (Medical Cessation Determination).

416.996 Continued disability or blindness benefits pending appeal of a medical cessation determination.

416.998 If you become disabled by another impairment(s).

Subpart J—Determinations of Disability

GENERAL PROVISIONS

416.1001 Purpose and scope.

416.1002 Definitions.

416.1003 Basic responsibilities for us and the State.

RESPONSIBILITIES FOR PERFORMING THE DISABILITY DETERMINATION FUNCTION

416.1010 How a State notifies us that it wishes to perform the disability determination function.

416.1011 How we notify a State whether it may perform the disability determination function.

416.1013 Disability determinations the State makes.

Social Security Administration

416.1014 Responsibilities for obtaining evidence to make disability determinations.

416.1015 Making disability determinations.

416.1016 Medical or psychological consultant.

416.1017 Reasonable efforts to obtain review by a qualified psychiatrist or psychologist.

416.1018 Notifying claimants of the disability determination.

ADMINISTRATIVE RESPONSIBILITIES AND REQUIREMENTS

416.1020 General administrative requirements.

416.1021 Personnel.

416.1022 Training.

416.1023 Facilities.

416.1024 Medical and other purchased services.

416.1025 Records and reports.

416.1026 Fiscal.

416.1027 Audits.

416.1028 Property.

416.1029 Participation in research and demonstration projects.

416.1030 Coordination with other agencies.

416.1031 Confidentiality of information and records.

416.1032 Other Federal laws and regulations.

416.1033 Policies and operating instructions.

PERFORMANCE STANDARDS

416.1040 General.

416.1041 Standards of performance.

416.1042 Processing time standard.

416.1043 Performance accuracy standard.

416.1044 How and when we determine whether the processing time standards are met.

416.1045 How and when we determine whether the performance accuracy standard is met.

416.1050 Action we will take if a State agency does not meet the standards.

PERFORMANCE MONITORING AND SUPPORT

416.1060 How we will monitor.

416.1061 When we will provide performance support.

416.1062 What support we will provide.

SUBSTANTIAL FAILURE

416.1070 General.

416.1071 Good cause for not following the Act, our regulations, or other written guidelines.

416.1075 Finding of substantial failure.

HEARINGS AND APPEALS

416.1080 Notice of right to hearing on proposed finding of substantial failure.

416.1081 Disputes on matters other than substantial failure.

416.1082 Who conducts the hearings.

416.1083 Hearings and appeals process.

ASSUMPTION OF DISABILITY DETERMINATION FUNCTION

416.1090 Assumption when we make a finding of substantial failure.

416.1091 Assumption when State no longer wishes to perform the disability determination function.

416.1092 Protection of State employees.

416.1093 Limitation on State expenditures after notice.

416.1094 Final accounting by the State.

Subpart K—Income

GENERAL

416.1100 Income and SSI eligibility.

416.1101 Definition of terms.

416.1102 What is income.

416.1103 What is not income.

416.1104 Income we count.

EARNED INCOME

416.1110 What is earned income.

416.1111 How we count earned income.

416.1112 Earned income we do not count.

UNEARNED INCOME

416.1120 What is unearned income.

416.1121 Types of unearned income.

416.1123 How we count unearned income.

416.1124 Unearned income we do not count.

IN-KIND SUPPORT AND MAINTENANCE

416.1130 Introduction.

416.1131 The one-third reduction rule.

416.1132 What we mean by "living in another person's household."

416.1133 What is a pro rata share of household operating expenses.

416.1140 The presumed value rule.

416.1141 When the presumed value rule applies.

416.1142 If you live in a public assistance household.

416.1143 If you live in a noninstitutional care situation.

416.1144 If you live in a nonprofit retirement home or similar institution.

416.1145 How the presumed value rule applies in a nonmedical for-profit institution.

IN-KIND SUPPORT AND MAINTENANCE IN SPECIAL CIRCUMSTANCES

416.1147 How we value in-kind support and maintenance for a couple.

416.1147a Income rules in change-of-status situations involving in-kind support and maintenance.

416.1148 If you have both in-kind support and maintenance and income that is deemed to you.

TEMPORARY ABSENCE

- 416.1149 What is a temporary absence from your living arrangement.

DISASTERS

- 416.1150 How we treat income received because of a major disaster.
416.1151 How we treat the repair or replacement of lost, damaged, or stolen resources.

HOME ENERGY ASSISTANCE

- 416.1157 Support and maintenance assistance.

DEEMING OF INCOME

- 416.1160 What is deeming of income.
416.1161 Income of an ineligible spouse, ineligible parent, and essential person for deeming purposes.
416.1161a Income for deeming purposes where Medicaid eligibility is affected.
416.1163 How we deem income to you from your ineligible spouse.
416.1165 How we deem income to you from your ineligible parent(s).
416.1166 How we deem income to you and your eligible child from your ineligible spouse.
416.1166a How we deem income to you from your sponsor if you are an alien.
416.1167 Temporary absences and deeming rules.
416.1168 How we deem income to you from your essential person.
416.1169 When we stop deeming income from an essential person.

ALTERNATIVE INCOME COUNTING RULES FOR CERTAIN BLIND INDIVIDUALS

- 416.1170 General.
416.1171 When the alternative rules apply.

RULES FOR HELPING BLIND AND DISABLED INDIVIDUALS ACHIEVE SELF-SUPPORT

- 416.1180 General.
416.1181 What a plan to achieve self-support is.
416.1182 When we begin to count the income excluded under the plan.

APPENDIX TO SUBPART K—LIST OF TYPES OF INCOME EXCLUDED UNDER THE SSI PROGRAM AS PROVIDED BY FEDERAL LAWS OTHER THAN THE SOCIAL SECURITY ACT

Subpart L—Resources and Exclusions

- 416.1201 Resources; general.
416.1202 Deeming of resources.
416.1203 Deeming of resources of an essential person.
416.1204 Deeming of resources of the sponsor of an alien.
416.1204a Deeming of resources where Medicaid eligibility is affected.

- 416.1205 Limitation on resources.
416.1207 Resources determinations.
416.1208 How funds held in financial institution accounts are counted.
416.1210 Exclusions from resources; general.
416.1212 Exclusion of the home.
416.1216 Exclusion of household goods and personal effects.
416.1218 Exclusion of the automobile.
416.1220 Property essential to self-support; general.
416.1222 How income-producing property essential to self-support is counted.
416.1224 How nonbusiness property used to produce goods or services essential to self-support is counted.
416.1225 An approved plan for self-support; general.
416.1226 What a plan to achieve self-support is.
416.1227 When the resources excluded under a plan to achieve self-support begin to count.
416.1228 Exclusion of Alaskan natives' stock in regional or village corporations.
416.1229 Exclusion of payments received as compensation for expenses incurred or losses suffered as a result of a crime.
416.1230 Exclusion of life insurance.
416.1231 Burial spaces and certain funds set aside for burial expenses.
416.1232 Replacement of lost, damaged, or stolen excluded resources.
416.1233 Exclusion of certain underpayments from resources.
416.1234 Exclusion of Indian lands.
416.1235 Exclusion of earned income tax credit.
416.1236 Exclusions from resources; provided by other statutes.
416.1237 Assistance received on account of major disaster.
416.1238 Exclusion of certain housing assistance.
416.1239 Exclusion of State or local relocation assistance payments.
416.1240 Disposition of resources.
416.1242 Time limits for disposing of resources.
416.1244 Treatment of proceeds from disposition of resources.
416.1245 Exceptions to required disposition of real property.
416.1246 Disposal of resources at less than fair market value.
416.1260 Special resource provision for recipients under a State plan.
416.1261 Application of special resource provision.
416.1262 Special resource provision applicable in cases involving essential persons.
416.1264 Spouse ineligible under a State plan in December 1973.
416.1266 Individual under special resource provision dies after December 1973.

Subpart M—Suspensions and Terminations

- 416.1321 Suspensions; general.
416.1322 Suspension due to failure to comply with request for information.
416.1323 Suspension due to excess income.
416.1324 Suspension due to excess resources.
416.1325 Suspension due to status as a resident of a public institution.
416.1326 Suspension for failure to comply with treatment for drug addiction or alcoholism.
416.1327 Suspension due to absence from the United States.
416.1328 Suspension due to refusal to accept vocational rehabilitation services.
416.1329 Suspension due to loss of United States residency, United States citizenship, or status as an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.
416.1330 Suspension due to failure to apply for and obtain other benefits.
416.1331 Termination of your disability or blindness payments.
416.1332 Termination of benefit for disabled individual: Exception.
416.1333 Termination at the request of the recipient.
416.1334 Termination due to death of recipient.
416.1335 Termination due to continuous suspension.
416.1336 Notice of intended action affecting recipient's payment status.
416.1337 Exceptions to the continuation of previously established payment level.
416.1338 If you are participating in a vocational rehabilitation program.

Subpart N—Determinations, Administrative Review Process, and Reopening of Determinations and Decisions

INTRODUCTION, DEFINITIONS, AND INITIAL DETERMINATIONS

- 416.1400 Introduction.
416.1401 Definitions.
416.1402 Administrative actions that are initial determinations.
416.1403 Administrative actions that are not initial determinations.
416.1404 Notice of the initial determination.
416.1405 Effect of an initial determination.
416.1406 Testing modifications to the disability determination procedures.

RECONSIDERATION

- 416.1407 Reconsideration—general.
416.1408 Parties to a reconsideration.
416.1409 How to request reconsideration.
416.1411 Good cause for missing the deadline to request review.
416.1413 Reconsideration procedures.

- 416.1413a Reconsiderations of initial determinations on applications.
416.1413b Reconsideration procedures for post-eligibility claims.
416.1413c Arrangement for conferences.
416.1414 Disability hearing—general.
416.1415 Disability hearing—disability hearing officers.
416.1416 Disability hearing—procedures.
416.1417 Disability hearing—disability hearing officer's reconsidered determination.
416.1418 Disability hearing—review of the disability hearing officer's reconsidered determination before it is issued.
416.1419 Notice of another person's request for reconsideration.
416.1420 Reconsidered determination.
416.1421 Effect of a reconsidered determination.
416.1422 Notice of a reconsidered determination.

EXPEDITED APPEALS PROCESS

- 416.1423 Expedited appeals process—general.
416.1424 When the expedited appeals process may be used.
416.1425 How to request expedited appeals process.
416.1426 Agreement in expedited appeals process.
416.1427 Effect of expedited appeals process agreement.
416.1428 Expedited appeals process request that does not result in agreement.

HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE

- 416.1429 Hearing before an administrative law judge—general.
416.1430 Availability of a hearing before an administrative law judge.
416.1432 Parties to a hearing before an administrative law judge.
416.1433 How to request a hearing before an administrative law judge.
416.1435 Submitting evidence prior to a hearing before an administrative law judge.
416.1436 Time and place for a hearing before an administrative law judge.
416.1438 Notice of a hearing before an administrative law judge.
416.1439 Objections to the issues.
416.1440 Disqualification of the administrative law judge.
416.1441 Prehearing case review.
416.1442 Prehearing proceedings and decisions by attorney advisors.
416.1443 Responsibilities of the adjudication officer.

ADMINISTRATIVE LAW JUDGE HEARING PROCEDURES

- 416.1444 Administrative law judge hearing procedures—general.
- 416.1446 Issues before an administrative law judge.
- 416.1448 Deciding a case without an oral hearing before an administrative law judge.
- 416.1449 Presenting written statements and oral arguments.
- 416.1450 Presenting evidence at a hearing before an administrative law judge.
- 416.1451 When a record of a hearing before an administrative law judge is made.
- 416.1452 Consolidated hearings before an administrative law judge.
- 416.1453 The decision of an administrative law judge.
- 416.1455 The effect of an administrative law judge's decision.
- 416.1456 Removal of a hearing request from an administrative law judge to the Appeals Council.
- 416.1457 Dismissal of a request for a hearing before an administrative law judge.
- 416.1458 Notice of dismissal of a request for a hearing before an administrative law judge.
- 416.1459 Effect of dismissal of a request for a hearing before an administrative law judge.
- 416.1460 Vacating a dismissal of a request for a hearing before an administrative law judge.
- 416.1461 Prehearing and posthearing conferences.
- 416.1465 [Reserved]

APPEALS COUNCIL REVIEW

- 416.1467 Appeals Council review—general.
- 416.1468 How to request Appeals Council review.
- 416.1469 Appeals Council initiates review.
- 416.1470 Cases the Appeals Council will review.
- 416.1471 Dismissal by Appeals Council.
- 416.1472 Effect of dismissal of request for Appeals Council review.
- 416.1473 Notice of Appeals Council review.
- 416.1474 Obtaining evidence from Appeals Council.
- 416.1475 Filing briefs with the Appeals Council.
- 416.1476 Procedures before Appeals Council on review.
- 416.1477 Case remanded by Appeals Council.
- 416.1479 Decision of Appeals Council.
- 416.1481 Effect of Appeals Council's decision or denial of review.
- 416.1482 Extension of time to file action in Federal district court.

COURT REMAND CASES

- 416.1483 Case remanded by a Federal court.
- 416.1484 Appeals Council review of administrative law judge decision in a case remanded by a Federal court.
- 416.1485 Application of circuit court law.

REOPENING AND REVISING DETERMINATIONS AND DECISIONS

- 416.1487 Reopening and revising determinations and decisions.
- 416.1488 Conditions for reopening.
- 416.1489 Good cause for reopening.
- 416.1491 Late completion of timely investigation.
- 416.1492 Notice of revised determination or decision.
- 416.1493 Effect of revised determination or decision.
- 416.1494 Time and place to request further review or a hearing on revised determination or decision.

PAYMENT OF CERTAIN TRAVEL EXPENSES

- 416.1495 Payment of certain travel expenses—general.
- 416.1496 Who may be reimbursed.
- 416.1498 What travel expenses are reimbursable.
- 416.1499 When and how to claim reimbursement.

Subpart O—Representation of Parties

- 416.1500 Introduction.
- 416.1503 Definitions.
- 416.1505 Who may be your representative.
- 416.1506 Notification of options for obtaining attorney representation.
- 416.1507 Appointing a representative.
- 416.1510 Authority of a representative.
- 416.1515 Notice or request to a representative.
- 416.1520 Fee for a representative's services.
- 416.1525 Request for approval of a fee.
- 416.1528 Proceedings before a State or Federal court.
- 416.1535 Services in a proceeding under title XVI of the Act.
- 416.1540 Rules governing representatives.
- 416.1545 What happens to a representative who breaks the rules.
- 416.1550 Notice of charges against a representative.
- 416.1555 Withdrawing charges against a representative.
- 416.1565 Hearing on charges.
- 416.1570 Decision by hearing officer.
- 416.1575 Requesting review of the hearing officer's decision.
- 416.1576 Assignment of request for review of the hearing officer's decision.
- 416.1580 Appeals Council's review of hearing officer's decision.
- 416.1585 Evidence permitted on review.
- 416.1590 Appeals Council's decision.

- 416.1595 When the Appeals Council will dismiss a request for review.
- 416.1597 Reinstatement after suspension—period of suspension expired.
- 416.1599 Reinstatement after suspension or disqualification—period of suspension not expired.

Subpart P—Residence and Citizenship

- 416.1600 Introduction.
- 416.1601 Definitions and terms used in this subpart.
- 416.1603 How to prove you are a resident of the United States.
- 416.1610 How to prove you are a citizen or a national of the United States.
- 416.1615 How to prove you are lawfully admitted for permanent residence in the United States.
- 416.1618 When you are considered permanently residing in the United States under color of law.
- 416.1619 When you cannot be considered permanently residing in the United States under color of law.

Subpart Q—Referral of Persons Eligible for Supplemental Security Income to Other Agencies

GENERAL

- 416.1701 Scope of subpart.
- 416.1705 Definitions.

REFERRAL FOR VOCATIONAL REHABILITATION SERVICES

- 416.1710 Whom we refer and when.
- 416.1715 Effect of your rejecting vocational rehabilitation services.

REFERRAL FOR TREATMENT OF ALCOHOLISM OR DRUG ADDICTION

- 416.1720 Whom we refer.
- 416.1725 Effect of your failure to comply with treatment requirements for your drug addiction or alcoholism.

Subpart R—Relationship

- 416.1801 Introduction.

WHO IS CONSIDERED YOUR SPOUSE

- 416.1802 Effects of marriage on eligibility and amount of benefits.
- 416.1806 Whether you are married and who is your spouse.
- 416.1816 Information we need concerning marriage when you apply for SSI.
- 416.1821 Showing that you are married when you apply for SSI.
- 416.1826 Showing that you are not married when you apply for SSI.
- 416.1830 When we stop considering you and your spouse an eligible couple.

- 416.1832 When we consider your marriage ended.
- 416.1835 Information we need about separation or end of marriage after you become eligible for SSI.

WHO IS CONSIDERED A CHILD

- 416.1851 Effects of being considered a child.
- 416.1856 Who is considered a child.
- 416.1861 Deciding whether you are a child: Are you a student?
- 416.1866 Deciding whether you are a child: Are you the head of a household?

WHO IS CONSIDERED YOUR PARENT

- 416.1876 Effects a parent (or parents) can have on the child's benefits.
- 416.1881 Deciding whether someone is your parent or stepparent.

Subpart S—Interim Assistance Provisions

INTRODUCTION

- 416.1901 Scope of subpart S.
- 416.1902 Definitions.

AUTHORIZATIONS

- 416.1904 Authorization to withhold SSI benefits.
- 416.1906 When your authorization is in effect.
- 416.1908 When we need another authorization.

INTERIM ASSISTANCE AGREEMENTS

- 416.1910 Requirements for interim assistance agreement.

APPEALS

- 416.1920 Your appeal rights in the State.
- 416.1922 Your appeal rights in SSA.

Subpart T—State Supplementation Provisions; Agreements; Payments

- 416.2001 State supplementary payments; general.
- 416.2005 Administration agreements with the Secretary.
- 416.2010 Essentials of the administration agreements.
- 416.2015 Establishing eligibility.
- 416.2020 Federally administered supplementary payments.
- 416.2025 Optional supplementation: Countable income.
- 416.2030 Optional supplementation: Variations in payments.
- 416.2035 Optional supplementation: Additional State options.
- 416.2040 Limitations on eligibility.
- 416.2045 Overpayments and underpayments; federally administered supplementation.
- 416.2047 Waiver of State supplementary payments.

- 416.2050 Mandatory minimum State supplementation.
- 416.2055 Mandatory minimum supplementation reduced.
- 416.2060 Mandatory minimum supplementary payments not applicable.
- 416.2065 Mandatory minimum State supplementation: Agreement deemed.
- 416.2070 Mandatory supplementation: State compliance not applicable.
- 416.2075 Monitoring of mandatory minimum supplementary payments.
- 416.2080 Limitation of fiscal liability of States.
- 416.2082 Non-Federal share of expenditures: defined.
- 416.2085 Adjusted payment level.
- 416.2090 State funds advanced for supplementary payments.
- 416.2095 Pass-along of Federal benefit increases.
- 416.2096 Basic pass-along rules.
- 416.2097 Combined supplementary/SSI payment levels.
- 416.2098 Supplementary payment levels.
- 416.2099 Compliance with pass-along.

Subpart U—Medicaid Eligibility Determinations

- 416.2101 Introduction.
- 416.2111 Conditions for our agreeing to make Medicaid eligibility determinations.
- 416.2116 Medicaid eligibility determinations.
- 416.2130 Effect of the agreement and responsibilities of States.
- 416.2140 Liability for erroneous Medicaid eligibility determinations.
- 416.2145 Services other than Medicaid determinations.
- 416.2161 Charges to States.
- 416.2166 Changing the agreement.
- 416.2171 Duration of agreement.
- 416.2176 Disagreements between a State and us.

Subpart V—Payments for Vocational Rehabilitation Services

GENERAL PROVISIONS

- 416.2201 General.
- 416.2202 Purpose and scope.
- 416.2203 Definitions.
- 416.2204 Participation by State VR agencies or alternate participants.
- 416.2206 Basic qualifications for alternate participants.

PAYMENT PROVISIONS

- 416.2208 Requirements for payment.
- 416.2209 Responsibility for making payment decisions.
- 416.2210 What we mean by "SGA" and by "a continuous period of 9 months".

- 416.2211 Criteria for determining when VR services will be considered to have contributed to a continuous period of 9 months.
- 416.2212 Payment for VR services in a case where an individual continues to receive disability or blindness payment based on participation in an approved VR program.
- 416.2213 Payment for VR services in a case of VR refusal.
- 416.2214 Services for which payment may be made.
- 416.2215 When services must have been provided.
- 416.2216 When claims for payment for VR services must be made (filing deadlines).
- 416.2217 What costs will be paid.

ADMINISTRATIVE PROVISIONS

- 416.2218 Applicability of these provisions to alternate participants
- 416.2219 Method of payment.
- 416.2220 Audits.
- 416.2221 Validation reviews.
- 416.2222 Confidentiality of information and records.
- 416.2223 Other Federal laws and regulations.
- 416.2227 Resolution of disputes.

Subpart A—Introduction, General Provisions and Definitions

AUTHORITY: Secs. 702(a)(5) and 1601-1635 of the Social Security Act (42 U.S.C. 902(a)(5) and 1381-1383d); sec. 212, Pub. L. 93-66, 87 Stat. 155 (42 U.S.C. 1382 note); sec. 502(a), Pub. L. 94-241, 90 Stat. 268 (48 U.S.C. 1681 note).

SOURCE: 39 FR 28625, Aug. 9, 1974, unless otherwise noted.

§416.101 Introduction.

The regulations in this part 416 (Regulations No. 16 of the Social Security Administration) relate to the provisions of title XVI of the Social Security Act as amended by section 301 of Pub. L. 92-603 enacted October 30, 1972, and as may thereafter be amended. Title XVI (Supplemental Security Income For The Aged, Blind, and Disabled) of the Social Security Act, as amended, established a national program, effective January 1, 1974, for the purpose of providing supplemental security income to individuals who have attained age 65 or are blind or disabled. The regulations in this part are divided into the following subparts according to subject content:

(a) This subpart A contains this introduction, a statement of the general purpose underlying the supplemental security income program, general provisions applicable to the program and its administration, and definitions and use of terms occurring throughout this part.

(b) Subpart B of this part covers in general the eligibility requirements which must be met for benefits under the supplemental security income program. It sets forth the requirements regarding residence, citizenship, age, disability, or blindness, and describes the conditions which bar eligibility and generally points up other conditions of eligibility taken up in greater detail elsewhere in the regulations (e.g., limitations on income and resources, receipt of support and maintenance, etc.).

(c) Subpart C of this part sets forth the rules with respect to the filing of applications, requests for withdrawal of applications, cancellation of withdrawal requests and other similar requests.

(d) Subpart D of this part sets forth the rules for computing the amount of benefits payable to an eligible individual and eligible spouse.

(e) Subpart E of this part covers provisions with respect to periodic payment of benefits, joint payments, payment of emergency cash advances, payment of benefits prior to a determination of disability, prohibition against transfer or assignment of benefits, adjustment and waiver of overpayments, and payment of underpayments.

(f) Subpart F of this part contains provisions with respect to the selection of representative payees to receive benefits on behalf of and for the use of recipients and to the duties and responsibilities of representative payees.

(g) Subpart G of this part sets forth rules with respect to the reporting of events and circumstances affecting eligibility or the amount of benefits payable.

(h) Subpart H of this part sets forth rules and guidelines for the submittal and evaluation of evidence of age where age is pertinent to establishing eligibility or the amount of benefits payable.

(i) Subpart I of this part sets forth the rules for establishing disability or blindness where the establishment of disability or blindness is pertinent to eligibility.

(j) Subpart J of this part sets forth the standards, requirements and procedures for States making determinations of disability for the Secretary. It also sets out the Secretary's responsibilities in carrying out the disability determination function.

(k) Subpart K of this part defines *income*, *earned income*, and *unearned income* and sets forth the statutory exclusions applicable to earned and unearned income for the purpose of establishing eligibility for and the amount of benefits payable.

(l) Subpart L of this part defines the term *resources* and sets forth the statutory exclusions applicable to resources for the purpose of determining eligibility.

(m) Subpart M of this part deals with events or circumstances requiring suspension or termination of benefits.

(n) Subpart N of this part contains provisions with respect to procedures for making determinations with respect to eligibility, amount of benefits, representative payment, etc., notices of determinations, rights of appeal and procedures applicable thereto, and other procedural due process provisions.

(o) Subpart O of this part contains provisions applicable to attorneys and other individuals who represent applicants in connection with claims for benefits.

(p) Subpart P of this part sets forth the residence and citizenship requirements that are pertinent to eligibility.

(q) Subpart Q of this part contains provisions with respect to the referral of individuals for vocational rehabilitation, treatment for alcoholism and drug addiction, and application for other benefits to which an applicant may be potentially entitled.

(r) Subpart R of this part sets forth the rules for determining marital and other family relationships where pertinent to the establishment of eligibility for or the amount of benefits payable.

(s) Subpart S of this part explains interim assistance and how benefits may

first learn that you should have made a required report, but did not do so within 10 days after the close of the month in which the event happened. (The event may have happened during the first penalty period, with the reporting due date in the second penalty period. The due date and the failure to report on time are the important factors in establishing a penalty period.) There may be more than one required report overdue at the end of the second penalty period, but we will impose no more than one penalty deduction for the period.

(b) *Extension of second penalty period.* If you have good cause for not making a report on time (see §416.732), we will extend the second penalty period to the day when we learn that you should have made another required report, but did not do so within 10 days after the close of the month in which the event happened. There may be more than one required report overdue at the end of the extended second penalty period, but we will impose no more than one penalty deduction for the extended period.

[46 FR 5873, Jan. 21, 1981, as amended at 50 FR 48573, Nov. 26, 1985]

§416.730 Penalty period: Three or more failures to report.

(a) *Third (or a following) penalty period.* A third (or a following) penalty period begins the day after the last penalty period ends. This penalty period ends on the day we first learn that you should have made a required report during the penalty period, but did not do so within 10 days after the close of the month in which the event happened. (The event may have happened during an earlier penalty period, with the reporting due date in the third (or a following) penalty period. The due date and the failure to report on time are the important factors in establishing a penalty period.) There may be more than one required report overdue at the end of a penalty period, but we will impose no more than one penalty deduction for any one penalty period.

(b) *Extension of third (or a following) penalty period.* Just as with the first and second penalty periods, if you have good cause for not making a report on time during the third (or a following)

penalty period (see §416.732), we will extend the penalty period to the day when we learn that you should have made another required report, but did not do so within 10 days after the close of the month in which the event happened. There may be more than one required report overdue at the end of an extended penalty period, but we will impose no more than one penalty deduction for any one extended penalty period.

[46 FR 5873, Jan. 21, 1981, as amended at 50 FR 48573, Nov. 26, 1985]

§416.732 No penalty deduction if you have good cause for failure to report timely.

(a) We will find that you have good cause for failure to report timely and we will not impose a penalty deduction, if—

(1) You are "without fault" as defined in §416.552; or

(2) Your failure or delay in reporting is not willful. "Not willful" means that—

(i) You did not have full knowledge of the existence of your obligation to make a required report; or

(ii) You did not intentionally, knowingly, and purposely fail to make a required report.

However, in either case we may require that you refund an overpayment caused by your failure to report. See subpart E of this part for waiver of recovery of overpayments.

(b) In determining whether you have good cause for failure to report timely, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) you may have.

[59 FR 1636, Jan. 12, 1994]

Subpart H—Determination of Age

AUTHORITY: Secs. 702(a)(5), 1601, 1614(a)(1) and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1381, 1382(a)(1), and 1383).

SOURCE: 39 FR 12731, Apr. 8, 1974, unless otherwise noted.

§416.801 Evidence as to age—when required.

An applicant for benefits under title XVI of the Act shall file supporting evidence showing the date of his birth if his age is a condition of eligibility for benefits or is otherwise relevant to the payment of benefits pursuant to such title XVI. Such evidence may also be required by the Administration as to the age of any other individual when such other individual's age is relevant to the determination of the applicant's eligibility or benefit amount. In the absence of evidence to the contrary, if the applicant alleges that he is at least 68 years of age and submits any documentary evidence at least 3 years old which supports his allegation, no further evidence of his age is required. In the absence of evidence to the contrary, if a State required reasonably acceptable evidence of age and provides a statement as to an applicant's age, no further evidence of his age is required unless a statistically valid quality control sample has shown that a State's determination of age procedures do not yield an acceptable low rate of error.

§416.802 Type of evidence to be submitted.

Where an individual is required to submit evidence of date of birth as indicated in §416.801, he shall submit a public record of birth or a religious record of birth or baptism established or recorded before his fifth birthday, if available. Where no such document recorded or established before age 5 is available the individual shall submit as evidence of age another document or documents which may serve as the basis for a determination of the individual's date of birth provided such evidence is corroborated by other evidence or by information in the records of the Administration.

§416.803 Evaluation of evidence.

Generally, the highest probative value will be accorded to a public record of birth or a religious record of birth or baptism established or recorded before age 5. Where such record is not available, and other documents are submitted as evidence of age, in determining their probative value, con-

sideration will be given to when such other documents were established or recorded, and the circumstances attending their establishment or recording. Among the documents which may be submitted for such purpose are: school record, census record, Bible or other family record, church record of baptism or confirmation in youth or early adult life, insurance policy, marriage record, employment record, labor union record, fraternal organization record, military record, voting record, vaccination record, delayed birth certificate, birth certificate of child of applicant, physician's or midwife's record of birth, immigration record, naturalization record, or passport.

§416.804 Certified copy in lieu of original.

In lieu of the original of any record, except a Bible or other family record, there may be submitted as evidence of age a copy of such record or a statement as to the date of birth shown by such record, which has been duly certified (see §404.701(g) of this chapter).

§416.805 When additional evidence may be required.

If the evidence submitted is not convincing, additional evidence may be required.

§416.806 Expedited adjudication based on documentary evidence of age.

Where documentary evidence of age recorded at least 3 years before the application is filed, which reasonably supports an aged applicant's allegation as to his age, is submitted, payment of benefits may be initiated even though additional evidence of age may be required by §§416.801 through 416.805. The applicant will be advised that additional evidence is required and that, if it is subsequently established that the prior finding of age is incorrect, the applicant will be liable for refund of any overpayment he has received. If any of the evidence initially submitted tends to show that the age of the applicant or such other person does not correspond with the alleged age, no benefits will be paid until the evidence required by §§416.801 through 416.805 is submitted.

Subpart I—Determining Disability and Blindness

AUTHORITY: Secs. 702(a)(5), 1611, 1614, 1619, 1631(a), (c), and (d)(1), and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1382, 1382c, 1382h, 1383(a), (c), and (d)(1), and 1383b); secs. 4(c) and 5, 6(c)-(e), 14(a) and 15, Pub. L. 98-460, 98 Stat. 1794, 1801, 1802, and 1806 (42 U.S.C. 421 note, 423 note, 1382h note).

SOURCE: 45 FR 55621, Aug. 20, 1980, unless otherwise noted.

GENERAL

§416.901 Scope of subpart.

In order for you to become entitled to any benefits based upon disability or blindness you must be disabled or blind as defined in title XVI of the Social Security Act. This subpart explains how we determine whether you are disabled or blind. We have organized the rules in the following way.

(a) We define general terms, then discuss who makes our disability or blindness determinations and state that disability and blindness determinations made under other programs are not binding on our determinations.

(b) We explain the term *disability* and note some of the major factors that are considered in determining whether you are disabled in §§416.905 through 416.910.

(c) Sections 416.912 through 416.918 contain our rules on evidence. We explain your responsibilities for submitting evidence of your impairment, state what we consider to be acceptable sources of medical evidence, and describe what information should be included in medical reports.

(d) Our general rules on evaluating disability for adults filing new applications are stated in §§416.920 through 416.923. We describe the steps that we go through and the order in which they are considered.

(e) Our general rules on evaluating disability for children filing new applications are stated in §§416.924 through 416.924e.

(f) Our rules on medical considerations are found in §§416.925 through 416.930. We explain in these rules—

(1) The purpose and use of the Listing of Impairments found in appendix 1 of subpart P of part 404 of this chapter;

(2) What we mean by the term *medical equivalence* and how we determine medical equivalence;

(3) The effect of a conclusion by your physician that you are disabled;

(4) What we mean by symptoms, signs, and laboratory findings;

(5) How we evaluate pain and other symptoms; and

(6) The effect on your benefits if you fail to follow treatment that is expected to restore your ability to work, and how we apply the rule.

(g) In §§416.931 through 416.934 we explain that we may make payments on the basis of presumptive disability or presumptive blindness.

(h) In §§416.935 through 416.939 we explain the rules which apply in cases of drug addiction and alcoholism.

(i) In §§416.945 through 416.946 we explain what we mean by the term *residual functional capacity*, state when an assessment of residual functional capacity is required, and who may make it.

(j) Our rules on vocational considerations are found in §§416.960 through 416.969a. We explain when vocational factors must be considered along with the medical evidence, discuss the role of residual functional capacity in evaluating your ability to work, discuss the vocational factors of age, education, and work experience, describe what we mean by work which exists in the national economy, discuss the amount of exertion and the type of skill required for work, describe how the Guidelines in appendix 2 of subpart P of part 404 of this chapter apply to claims under part 416, and explain when, for purposes of applying the Guidelines in appendix 2, we consider the limitations or restrictions imposed by your impairment(s) and related symptoms to be exertional, nonexertional, or a combination of both.

(k) Our rules on substantial gainful activity are found in §§416.971 through 416.974. These explain what we mean by substantial gainful activity and how we evaluate your work activity.

(l) In §§416.981 through 416.985 we discuss blindness.

(m) Our rules on when disability or blindness continues and stops are contained in §§416.986 and 416.988 through

416.998. We explain what your responsibilities are in telling us of any events that may cause a change in your disability or blindness status, when you may have a trial work period, and when we will review to see if you are still disabled. We also explain how we consider the issue of medical improvement (and the exceptions to medical improvement) in determining whether you are still disabled.

[45 FR 55621, Aug. 20, 1980, as amended at 50 FR 50136, Dec. 6, 1985; 56 FR 5553, Feb. 11, 1991; 56 FR 57944, Nov. 14, 1991]

§416.902 General definitions and terms for this subpart.

As used in this subpart—

Adult means a person who is age 18 or older.

Child means a person who has not attained age 18.

Medical sources refers to treating sources, sources of record, and consultative examiners for us. See §416.913.

Secretary means the Secretary of Health and Human Services.

Source of record means a hospital, clinic or other source that has provided you with medical treatment or evaluation, as well as a physician or psychologist who has treated or evaluated you but does not have or did not have an ongoing treatment relationship with you.

State agency means that agency of a State which has been designated by the State to carry out the disability or blindness determination function.

Treating source means your own physician or psychologist who has provided you with medical treatment or evaluation and who has or has had an ongoing treatment relationship with you. Generally, we will consider that you have an ongoing treatment relationship with a physician or psychologist when the medical evidence establishes that you see or have seen the physician or psychologist with a frequency consistent with accepted medical practice for the type of treatment and evaluation required for your medical condition(s). We may consider a physician or psychologist who has treated you only a few times or only after long intervals (e.g., twice a year) to be your treating source if the nature and frequency of the treatment is typical for your

condition(s). We will not consider a physician or psychologist to be your treating physician if your relationship with the physician or psychologist is not based on your need for treatment, but solely on your need to obtain a report in support of your claim for benefits. In such a case, we will consider the physician or psychologist to be a consulting physician or psychologist.

We or us refers to either the Social Security Administration or the State agency making the disability or blindness determination.

You refers to the person who has applied for or is receiving benefits based on disability or blindness.

[56 FR 36962, Aug. 1, 1991, as amended at 58 FR 47577, Sept. 9, 1993]

DETERMINATIONS

§416.903 Who makes disability and blindness determinations.

(a) *State agencies.* State agencies make disability and blindness determinations for the Secretary for most persons living in the State. State agencies make these disability and blindness determinations under regulations containing performance standards and other administrative requirements relating to the disability and blindness determination function. States have the option of turning the function over to the Federal Government if they no longer want to make disability determinations. Also, the Secretary may take the function away from any State which has substantially failed to make disability and blindness determinations in accordance with these regulations. Subpart J of this part contains the rules the States must follow in making disability and blindness determinations.

(b) *Social Security Administration.* The Social Security Administration will make disability and blindness determinations for the Secretary for—

(1) Any person living in a State which is not making for the Secretary any disability and blindness determinations or which is not making those determinations for the class of claimants to which that person belongs; and

(2) Any person living outside the United States.

(c) *What determinations are authorized.* The Secretary has authorized the State agencies and the Social Security Administration to make determinations about—

(1) Whether you are disabled or blind;
(2) The date your disability or blindness began; and

(3) The date your disability or blindness stopped.

(d) *Review of State agency determinations.* On review of a State agency determination or redetermination of disability or blindness we may find that—

(1) You are, or are not, disabled or blind, regardless of what the State agency found;

(2) Your disability or blindness began earlier or later than the date found by the State agency; and

(3) Your disability or blindness stopped earlier or later than the date found by the State agency.

(e) *Initial determinations for mental impairments.* An initial determination by a State agency or the Social Security Administration that you are not disabled (or a Social Security Administration review of a State agency's initial determination), in any case where there is evidence which indicates the existence of a mental impairment, will be made only after every reasonable effort has been made to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment. (See §416.1016 for the qualifications we consider necessary for a psychologist to be a psychological consultant and §416.1017 for what we consider *reasonable effort*.) If the services of qualified psychiatrists or psychologists cannot be obtained because of impediments at the State level, the Secretary may contract directly for the services. In a case where there is evidence of mental and nonmental impairments and a qualified psychologist serves as a psychological consultant, the psychologist will evaluate only the mental impairment, and a physician will evaluate the nonmental impairment. The overall determination of impairment severity in combined mental and nonmental impairment cases will be made by a medical consultant other than a qualified psychologist unless the mental impairment

alone would justify a finding of disability.

(f) *Determinations for childhood impairments.* In making a determination under title XVI with respect to the disability of a child to whom paragraph (e) of this section does not apply, we will make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the child's impairment(s) evaluates the case of the child.

[46 FR 29211, May 29, 1981, as amended at 52 FR 33927, Sept. 9, 1987; 58 FR 47577, Sept. 9, 1993]

§416.903a Program integrity.

We will not use in our program any individual or entity, except to provide existing medical evidence, who is currently excluded, suspended, or otherwise barred from participation in the Medicare or Medicaid programs, or any other Federal or Federally-assisted program; whose license to provide health care services is currently revoked or suspended by any State licensing authority pursuant to adequate due process procedures for reasons
pete
cial
term
such
nary
sions
ual
psyc
exan
test
416.9

*Will need
revision*

[56 FR 30000, Aug. 1, 1991]

§416.904 Determinations by other organizations and agencies.

A decision by any nongovernmental agency or any other governmental agency about whether you are disabled or blind is based on its rules and is not our decision about whether you are disabled or blind. We must make a disability or blindness determination based on social security law. Therefore, a determination made by another agency that you are disabled or blind is not binding on us.

DEFINITION OF DISABILITY

§416.905 Basic definition of disability for adults.

(a) The law defines disability as the inability 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. To meet this definition, you must have a severe impairment, which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy. To determine whether you are able to do any other work, we consider your residual functional capacity and your age, education, and work experience (see §416.920).

(b) There are different rules for determining disability for individuals who are statutorily blind. We discuss these in §§416.981 through 416.985.

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 5553, Feb. 11, 1991]

§416.906 Basic definition of disability for children.

If you are under age 18, we will consider you disabled if you are suffering from any medically determinable physical or mental impairment which compares in severity to an impairment that would make an adult (a person over age 18) disabled. We discuss our rules for determining disability in children in §§416.924, and 416.924a through 416.924e.

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 5553, Feb. 11, 1991]

§416.907 Disability under a State plan.

You will also be considered disabled for payment of supplemental security income benefits if—

(a) You were found to be permanently and totally disabled as defined under a State plan approved under title XIV or XVI of the Social Security Act, as in effect for October 1972;

(b) You received aid under the State plan because of your disability for the month of December 1973 and for at least one month before July 1973; and

(c) You continue to be disabled as defined under the State plan.

§416.908 What is needed to show an impairment.

If you are not doing substantial gainful activity, we always look first at your physical or mental impairment(s) to determine whether you are disabled or blind. Your impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by your statement of symptoms (see §416.927). (See §416.928 for further information about what we mean by symptoms, signs, and laboratory findings.)

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 36963, Aug. 1, 1991]

§416.909 How long the impairment must last.

Unless your impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months. We call this the duration requirement.

§416.910 Meaning of substantial gainful activity.

Substantial gainful activity means work that—

(a) Involves doing significant and productive physical or mental duties; and

(b) Is done (or intended) for pay or profit.

(See §416.972 for further details about what we mean by substantial gainful activity.)

§416.911 Definition of disabling impairment.

A disabling impairment is an impairment (or combination of impairments) which, of itself, is so severe that it meets or equals a set of criteria in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter or which, when considered with your age, education and work experience, would result in a finding that you are disabled under §416.994. In determining

(c) *What determinations are authorized.* The Secretary has authorized the State agencies and the Social Security Administration to make determinations about—

- (1) Whether you are disabled or blind;
- (2) The date your disability or blindness began; and
- (3) The date your disability or blindness stopped.

(d) *Review of State agency determinations.* On review of a State agency determination or redetermination of disability or blindness we may find that—

- (1) You are, or are not, disabled or blind, regardless of what the State agency found;

- (2) Your disability or blindness began earlier or later than the date found by the State agency; and

- (3) Your disability or blindness stopped earlier or later than the date found by the State agency.

(e) *Initial determinations for mental impairments.* An initial determination by a State agency or the Social Security Administration that you are not disabled (or a Social Security Administration review of a State agency's initial determination), in any case where there is evidence which indicates the existence of a mental impairment, will be made only after every reasonable effort has been made to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment. (See §416.1016 for the qualifications we consider necessary for a psychologist to be a psychological consultant and §416.1017 for what we consider *reasonable effort*.) If the services of qualified psychiatrists or psychologists cannot be obtained because of impediments at the State level, the Secretary may contract directly for the services. In a case where there is evidence of mental and nonmental impairments and a qualified psychologist serves as a psychological consultant, the psychologist will evaluate only the mental impairment, and a physician will evaluate the nonmental impairment. The overall determination of impairment severity in combined mental and nonmental impairment cases will be made by a medical consultant other than a qualified psychologist unless the mental impairment

alone would justify a finding of disability.

(f) *Determinations for childhood impairments.* In making a determination under title XVI with respect to the disability of a child to whom paragraph (e) of this section does not apply, we will make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the child's impairment(s) evaluates the case of the child.

[46 FR 29211, May 29, 1981, as amended at 52 FR 33927, Sept. 9, 1987; 58 FR 47577, Sept. 9, 1993]

§416.903a Program integrity.

We will not use in our program any individual or entity, except to provide existing medical evidence, who is currently excluded, suspended, or otherwise barred from participation in the Medicare or Medicaid programs, or any other Federal or Federally-assisted program; whose license to provide health care services is currently revoked or suspended by any State licensing authority pursuant to adequate due process procedures for reasons bearing on professional competence, professional conduct, or financial integrity; or who until a final determination is made has surrendered such a license while formal disciplinary proceedings involving professional conduct are pending. By individual or entity we mean a medical or psychological consultant, consultative examination provider, or diagnostic test facility. Also see §§416.919 and 416.919g(b).

[56 FR 36963, Aug. 1, 1991]

§416.904 Determinations by other organizations and agencies.

A decision by any nongovernmental agency or any other governmental agency about whether you are disabled or blind is based on its rules and is not our decision about whether you are disabled or blind. We must make a disability or blindness determination based on social security law. Therefore, a determination made by another agency that you are disabled or blind is not binding on us.

DEFINITION OF DISABILITY

§416.905 Basic definition of disability for adults.

(a) The law defines disability as the inability 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. To meet this definition, you must have a severe impairment, which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy. To determine whether you are able to do any other work, we consider your residual functional capacity and your age, education, and work experience (see §416.920).

(b) There are different rules for determining disability for individuals who are statutorily blind. We discuss these in §§416.981 through 416.985.

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 5553, Feb. 11, 1991]

§416.906 Basic definition of disability for children.

If you are under age 18, we will consider you disabled if you are suffering from any medically determinable physical or mental impairment which compares in severity to an impairment that would make an adult (a person over age 18) disabled. We discuss our rules for determining disability in children in §§416.924, and 416.924a through 416.924e.

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 5553, Feb. 11, 1991]

§416.907 Disability under a State plan.

You will also be considered disabled for payment of supplemental security income benefits if—

(a) You were found to be permanently and totally disabled as defined under a State plan approved under title XIV or XVI of the Social Security Act, as in effect for October 1972;

(b) You received aid under the State plan because of your disability for the month of December 1973 and for at least one month before July 1973; and

(c) You continue to be disabled as defined under the State plan.

§416.908 What is needed to show an impairment.

If you are not doing substantial gainful activity, we always look first at your physical or mental impairment(s) to determine whether you are disabled or blind. Your impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by your statement of symptoms (see §416.927). (See §416.928 for further information about what we mean by symptoms, signs, and laboratory findings.)

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 36963, Aug. 1, 1991]

§416.909 How long the impairment must last.

Unless your impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months. We call this the duration requirement.

§416.910 Meaning of substantial gainful activity.

Substantial gainful activity means work that—

(a) Involves doing significant and productive physical or mental duties; and

(b) Is done (or intended) for pay or profit.

(See §416.972 for further details about what we mean by substantial gainful activity.)

§416.911 Definition of disabling impairment.

A disabling impairment is an impairment (or combination of impairments) which, of itself, is so severe that it meets or equals a set of criteria in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter or which, when considered with your age, education and work experience, would result in a finding that you are disabled under §416.994. In determining

whether you have a disabling impairment, earnings are not considered.

[50 FR 50137, Dec. 6, 1985]

EVIDENCE

§416.912 Evidence of your impairment.

(a) *General.* In general, you have to prove to us that you are blind or disabled. Therefore, you must bring to our attention everything that shows that you are blind or disabled. This means that you must furnish medical and other evidence that we can use to reach conclusions about your medical impairment(s) and, if material to the determination of whether you are blind or disabled, its effect on your ability to work on a sustained basis. We will consider only impairment(s) you say you have or about which we receive evidence.

(b) *What we mean by "evidence."* Evidence is anything you or anyone else submits to us or that we obtain that relates to your claim. This includes, but is not limited to:

(1) Objective medical evidence, that is, medical signs and laboratory findings as defined in §416.928 (b) and (c);

(2) Other evidence from medical sources, such as medical history, opinions, and statements about treatment you have received;

(3) Statements you or others make about your impairment(s), your restrictions, your daily activities, your efforts to work, or any other relevant statements you make to medical sources during the course of examination or treatment, or to us during interviews, on applications, in letters, and in testimony in our administrative proceedings;

(4) Information from other sources, as described in §416.913(e);

(5) Decisions by any governmental or nongovernmental agency about whether you are disabled or blind; and

(6) At the administrative law judge and Appeals Council levels, certain findings, other than the ultimate determination about whether you are disabled, made by State agency medical or psychological consultants and other program physicians or psychologists, and opinions expressed by medical advisors based on their review of the evi-

dence in your case record. See §416.927(f) (2) and (3).

(c) *Your responsibility.* You must provide medical evidence showing that you have an impairment(s) and how severe it is during the time you say that you are disabled. If we ask you, you must also provide evidence about:

(1) Your age;

(2) Your education and training;

(3) Your work experience;

(4) Your daily activities both before and after the date you say that you became disabled;

(5) Your efforts to work; and

(6) Any other factors showing how your impairment(s) affects your ability to work. In §§416.960 through 416.969, we discuss in more detail the evidence we need when we consider vocational factors.

(d) *Our responsibility.* Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical reports from your own medical sources when you give us permission to request the reports.

(1) "Every reasonable effort" means that we will make an initial request for evidence from your medical source and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one followup request to obtain the medical evidence necessary to make a determination. The medical source will have a minimum of 10 calendar days from the date of our followup request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case.

(2) By "complete medical history," we mean the records of your medical source(s) covering at least the 12 months preceding the month in which you file your application. If you say that your disability began less than 12 months before you filed your application, we will develop your complete

medical history beginning with the month you say your disability began unless we have reason to believe that your disability began earlier.

(e) *Recontacting medical sources.* When the evidence we receive from your treating physician or psychologist or other medical source is inadequate for us to determine whether you are disabled, we will need additional information to reach a determination or a decision. To obtain the information, we will take the following actions.

(1) We will first recontact your treating physician or psychologist or other medical source to determine whether the additional information we need is readily available. We will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques. We may do this by requesting copies of your medical source's records, a new report, or a more detailed report from your medical source, including your treating source, or by telephoning your medical source. In every instance where medical evidence is obtained over the telephone, the telephone report will be sent to the source for review, signature and return.

(2) We may not seek additional evidence or clarification from a medical source when we know from past experience that the source either cannot or will not provide the necessary findings.

(f) *Need for consultative examination.* If the information we need is not readily available from the records of your medical treatment source, or we are unable to seek clarification from your medical source, we will ask you to attend one or more consultative examinations at our expense. See §§416.917 through 416.919t for the rules governing the consultative examination process. Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources. However, in some instances, such as when a source is known to be unable to provide certain tests or procedures or

is known to be nonproductive or uncooperative, we may order a consultative examination while awaiting receipt of medical source evidence. We will not evaluate this evidence until we have made every reasonable effort to obtain evidence from your medical sources.

[56 FR 36963, Aug. 1, 1991]

§416.913 Medical evidence of your impairment.

(a) *Acceptable sources.* We need reports about your impairments from acceptable medical sources. Acceptable medical sources are—

(1) Licensed physicians;

(2) Licensed osteopaths;

(3) Licensed or certified psychologists;

(4) Licensed optometrists for the measurement of visual acuity and visual fields (see paragraph (f) of this section for the evidence needed for statutory blindness); and

(5) Persons authorized to send us a copy or summary of the medical records of a hospital, clinic, sanatorium, medical institution, or health care facility. Generally, the copy or summary should be certified as accurate by the custodian or by any authorized employee of the Social Security Administration, Veterans' Administration, or State agency. However, we will not return an uncertified copy or summary for certification unless there is some question about the document.

(6) A report of an interdisciplinary team that contains the evaluation and signature of an acceptable medical source is also considered acceptable medical evidence.

(b) *Medical reports.* Medical reports should include—

(1) Medical history;

(2) Clinical findings (such as the results of physical or mental status examinations);

(3) Laboratory findings (such as blood pressure, X-rays);

(4) Diagnosis (statement of disease or injury based on its signs and symptoms);

(5) Treatment prescribed with response, and prognosis; and

(6) A statement about what you can still do despite your impairment(s) based on the medical source's findings on the factors under paragraphs (b)(1)

through (b)(5) of this section (except in statutory blindness claims). Although we will request a medical source statement about what you can still do despite your impairment(s), the lack of the medical source statement will not make the report incomplete. See §416.927.

(c) *Statements about what you can still do.* Statements about what you can still do (based on the medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section) should describe, but are not limited to, the kinds of physical and mental capabilities listed below. See §§416.927 and 416.945(c).

(1) The medical source's opinion about your ability, despite your impairment(s), to do work-related activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling; and

(2) In cases of mental impairment(s), the medical source's opinion about your ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and work pressures in a work setting.

(3) If you are a child, the medical source's opinion about your physical or mental abilities to function independently, appropriately, and effectively in an age-appropriate manner, as described in §416.924d.

(d) *Completeness.* The medical evidence, including the clinical and laboratory findings, must be complete and detailed enough to allow us to make a determination about whether you are disabled or blind. It must allow us to determine—

(1) The nature and limiting effects of your impairment(s) for any period in question;

(2) The probable duration of your impairment; and

(3) Your residual functional capacity to do work-related physical and mental activities.

(e) *Information from other sources.* Information from other sources may also help us to understand how your impairment(s) affects your ability to work or, if you are a child, your ability to function independently, appropriately, and effectively in an age-appropriate manner. Other sources may include, and are not limited to—

(1) Public and private social welfare agencies and social workers;

(2) Observations by people who know you (for example, spouses, parents and other caregivers, siblings, other relatives, friends or neighbors, clergy);

(3) Other practitioners (for example, nurse practitioners and physicians' assistants, naturopaths, and chiropractors);

(4) Therapists (for example, physical, occupational, or speech and language therapists); and

(5) Educational agencies and personnel (for example, school teachers, school psychologists who are not acceptable medical sources under paragraph (a), school counselors, preschools, early intervention teams, developmental centers, and daycare centers).

(f) *Evidence we need to establish statutory blindness.* If you are applying for benefits on the basis of statutory blindness, we will require an examination by a physician skilled in diseases of the eye or by an optometrist, whichever you may select.

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 5553, Feb. 11, 1991; 56 FR 36964, Aug. 1, 1991; 58 FR 47577, Sept. 9, 1993]

§416.914 When we will purchase existing evidence.

We need specific medical evidence to determine whether you are disabled or blind. We will pay for the medical evidence we request, if there is a charge. We will also be responsible for the cost of medical evidence we ask you to get.

§416.915 Where and how to submit evidence.

You may give us evidence about your impairment at any of our offices or at the office of any State agency authorized to make disability or blindness determinations. You may also give evidence to one of our employees authorized to accept evidence at another place. For more information about this, see subpart C of this part.

§416.916 If you fail to submit medical and other evidence.

You (and if you are a child, your parent, guardian, relative, or other person

acting on your behalf) must co-operate in furnishing us with, or in helping us to obtain or identify, available medical or other evidence about your impairment(s). When you fail to co-operate with us in obtaining evidence, we will have to make a decision based on information available in your case. We will not excuse you from giving us evidence because you have religious or personal reasons against medical examinations, tests, or treatment.

[58 FR 47577, Sept. 9, 1993]

§416.917 Consultative examination at our expense.

If your medical sources cannot or will not give us sufficient medical evidence about your impairment for us to determine whether you are disabled or blind, we may ask you to have one or more physical or mental examinations or tests. We will pay for these examinations. However, we will not pay for any medical examination arranged by you or your representative without our advance approval. If we arrange for the examination or test, we will give you reasonable notice of the date, time, and place the examination or test will be given, and the name of the person or facility who will do it. We will also give the examiner any necessary background information about your condition.

[56 FR 36964, Aug. 1, 1991]

§416.918 If you do not appear at a consultative examination.

(a) *General.* If you are applying for benefits and do not have a good reason for failing or refusing to take part in a consultative examination or test which we arrange for you to get information we need to determine your disability or blindness, we may find that you are not disabled or blind. If you are already receiving benefits and do not have a good reason for failing or refusing to take part in a consultative examination or test which we arranged for you, we may determine that your disability or blindness has stopped because of your failure or refusal. Therefore, if you have any reason why you cannot go for the scheduled appointment, you should tell us about this as soon as possible before the examination date. If

you have a good reason, we will schedule another examination. We will consider your physical, mental, educational, and linguistic limitations (including any lack of facility with the English language) when determining if you have a good reason for failing to attend a consultative examination.

(b) *Examples of good reasons for failure to appear.* Some examples of what we consider good reasons for not going to a scheduled examination include—

(1) Illness on the date of the scheduled examination or test;

(2) Not receiving timely notice of the scheduled examination or test, or receiving no notice at all;

(3) Being furnished incorrect or incomplete information, or being given incorrect information about the physician involved or the time or place of the examination or test, or;

(4) Having had death or serious illness occur in your immediate family.

(c) *Objections by your physician.* If any of your treating physicians tell you that you should not take the examination or test, you should tell us at once. In many cases, we may be able to get the information we need in another way. Your physician may agree to another type of examination for the same purpose.

[45 FR 55621, Aug. 20, 1980, as amended at 59 FR 1636, Jan. 12, 1994]

STANDARDS TO BE USED IN DETERMINING WHEN A CONSULTATIVE EXAMINATION WILL BE OBTAINED IN CONNECTION WITH DISABILITY DETERMINATIONS

§416.919 The consultative examination.

A consultative examination is a physical or mental examination or test purchased for you at our request and expense from a treating physician or psychologist, another source of record, or an independent source, including a pediatrician when appropriate. The decision to purchase a consultative examination will be made on an individual case basis in accordance with the provisions of §416.919a through §416.919f. Selection of the source for the examination will be consistent with the provisions of §416.903a and §§416.919g

through 416.919j. The rules and procedures for requesting consultative examinations set forth in §§416.919a and 416.919b are applicable at the reconsideration and hearing levels of review, as well as the initial level of determination.

[56 FR 36964, Aug. 1, 1991]

§416.919a When we will purchase a consultative examination and how we will use it.

(a)(1) *General.* The decision to purchase a consultative examination for you will be made after we have given full consideration to whether the additional information needed (e.g., clinical findings, laboratory tests, diagnosis, and prognosis) is readily available from the records of your medical sources. See §416.912 for the procedures we will follow to obtain evidence from your medical sources. Before purchasing a consultative examination, we will consider not only existing medical reports, but also the disability interview form containing your allegations as well as other pertinent evidence in your file.

(2) When we purchase a consultative examination, we will use the report from the consultative examination to try to resolve a conflict or ambiguity if one exists. We will also use a consultative examination to secure needed medical evidence the file does not contain such as clinical findings, laboratory tests, a diagnosis or prognosis necessary for decision.

(b) *Situations requiring a consultative examination.* A consultative examination may be purchased when the evidence as a whole, both medical and nonmedical, is not sufficient to support a decision on your claim. Other situations, including but not limited to the situations listed below, will normally require a consultative examination:

- (1) The additional evidence needed is not contained in the records of your medical sources;
- (2) The evidence that may have been available from your treating or other medical sources cannot be obtained for reasons beyond your control, such as death or noncooperation of a medical source;
- (3) Highly technical or specialized medical evidence that we need is not

available from your treating or other medical sources;

(4) A conflict, inconsistency, ambiguity or insufficiency in the evidence must be resolved, and we are unable to do so by recontacting your medical source; or

(5) There is an indication of a change in your condition that is likely to affect your ability to work, but the current severity of your impairment is not established.

[56 FR 36964, Aug. 1, 1991]

§416.919b When we will not purchase a consultative examination.

We will not purchase a consultative examination in situations including, but not limited to, the following situations:

(a) When any issues about your actual performance of substantial gainful activity have not been resolved;

(b) When you do not meet all of the nondisability requirements.

[56 FR 36965, Aug. 1, 1991]

STANDARDS FOR THE TYPE OF REFERRAL AND FOR REPORT CONTENT

§416.919f Type of purchased examinations.

We will purchase only the specific examinations and tests we need to make a determination in your claim. For example, we will not authorize a comprehensive medical examination when the only evidence we need is a special test, such as an X-ray, blood studies, or an electrocardiogram.

[56 FR 36965, Aug. 1, 1991]

§416.919g Who we will select to perform a consultative examination.

(a) We will purchase a consultative examination only from a qualified medical source. The medical source may be your own physician or psychologist, or another source. If you are a child, the medical source we choose may be a pediatrician. For a more complete list of medical sources, see §416.913(a).

(b) By "qualified," we mean that the medical source must be currently licensed in the State and have the training and experience to perform the type of examination or test we will request;

the medical source must not be barred from participation in our programs under the provisions of §416.903a. The medical source must also have the equipment required to provide an adequate assessment and record of the existence and level of severity of your alleged impairments.

(c) The physician or psychologist we choose may use support staff to help perform the consultative examination. Any such support staff (e.g., X-ray technician, nurse) must meet appropriate licensing or certification requirements of the State. See §416.903a.

[56 FR 36965, Aug. 1, 1991]

§416.919h Your treating physician or psychologist.

When in our judgment your treating physician or psychologist is qualified, equipped, and willing to perform the additional examination or tests for the fee schedule payment, and generally furnishes complete and timely reports, your treating physician or psychologist will be the preferred source to do the purchased examination. Even if only a supplemental test is required, your treating physician or psychologist is ordinarily the preferred source.

[56 FR 36965, Aug. 1, 1991]

§416.919i Other sources for consultative examinations.

We will use a source other than your treating physician or psychologist for a purchased examination or test in situations including, but not limited to, the following situations:

(a) Your treating physician or psychologist prefers not to perform such an examination or does not have the equipment to provide the specific data needed;

(b) There are conflicts or inconsistencies in your file which cannot be resolved by going back to your treating physician or psychologist;

(c) You prefer a source other than your treating physician or psychologist and have a good reason for your preference;

(d) We know from prior experience that your treating physician or psychologist may not be a productive source, e.g., he or she has consistently

failed to provide complete or timely reports.

[56 FR 36965, Aug. 1, 1991]

§416.919j Objections to the designated physician or psychologist.

You or your representative may object to your being examined by a designated physician or psychologist. If there is a good reason for the objection, we will schedule the examination with another physician or psychologist. A good reason may be that the consultative examination physician or psychologist had previously represented an interest adverse to you. For example, the physician or psychologist may have represented your employer in a workers' compensation case or may have been involved in an insurance claim or legal action adverse to you. Other things we will consider include: the presence of a language barrier, the physician's or psychologist's office location (e.g., 2nd floor, no elevator), travel restrictions, and whether the physician or psychologist had examined you in connection with a previous disability determination or decision that was unfavorable to you. If your objection is because a physician or psychologist allegedly "lacks objectivity" in general, but not in relation to you personally, we will review the allegations. See §416.919s. To avoid a delay in processing your claim, the consultative examination in your case will be changed to another physician or psychologist while a review is being conducted. We will handle any objection to use of the substitute physician or psychologist in the same manner. However, if we had previously conducted such a review and found that the reports of the consultative physician or psychologist in question conformed to our guidelines, we will not change your examination.

[56 FR 36965, Aug. 1, 1991]

§416.919k Purchase of medical examinations, laboratory tests, and other services.

We may purchase medical examinations, including psychiatric and psychological examinations, X-rays and laboratory tests (including specialized

tests such as pulmonary function studies, electrocardiograms, stress tests, etc.) from a licensed physician or psychologist, hospital or clinic.

(a) The rate of payment to be used for purchasing medical or public services necessary to make determinations of disability may not exceed the highest rate paid by Federal or public agencies in the State for the same or similar types of service. See §§416.1024 and 416.1026.

(b) If a physician's bill, or a request for payment for a physician's services, includes a charge for a laboratory test for which payment may be made under this part, the amount payable with respect to the test shall be determined as follows:

(1) If the bill or request for payment indicates that the test was personally performed or supervised by the physician who submitted the bill (or for whose services the request for payment was made) or by another physician with whom that physician shares his or her practice, the payment will be based on the physician's usual and customary charge for the test or the rates of payment which the State uses for purchasing such services, whichever is the lesser amount.

(2) If the bill or request for payment indicates that the test was performed by an independent laboratory, the amount of reimbursement will not exceed the billed cost of the independent laboratory or the rate of payment which the State uses for purchasing such services, whichever is the lesser amount. A nominal payment may be made to the physician for collecting, handling and shipping a specimen to the laboratory if the physician bills for such a service. The total reimbursement may not exceed the rate of payment which the State uses for purchasing such services.

(c) The State will assure that it can support the rate of payment it uses. The State shall also be responsible for monitoring and overseeing the rate of payment it uses to ensure compliance with paragraphs (a) and (b) of this section.

[56 FR 36965, Aug. 1, 1991]

§416.919m Diagnostic tests or procedures.

We will request the results of any diagnostic tests or procedures that have been performed as part of a workup by your treating physician or psychologist or other medical source and will use the results to help us evaluate impairment severity or prognosis. However, we will not order diagnostic tests or procedures that involve significant risk to you, such as myelograms, arteriograms, or cardiac catheterizations for the evaluation of disability under the Supplemental Security Income program. Also, a State agency medical consultant must approve the ordering of any diagnostic test or procedure when there is a chance it may involve significant risk. The responsibility for deciding whether to perform the examination rests with the consultative examining physician or psychologist.

[56 FR 36966, Aug. 1, 1991]

§416.919n Informing the examining physician or psychologist of examination scheduling, report content, and signature requirements.

The physicians or psychologists who perform consultative examinations will have a good understanding of our disability programs and their evidentiary requirements. They will be made fully aware of their responsibilities and obligations regarding confidentiality as described in §401.105(e). We will fully inform consulting physicians or psychologists at the time we first contact them, and at subsequent appropriate intervals, of the following obligations:

(a) In scheduling full consultative examinations, sufficient time should be allowed to permit the examining physician or psychologist to take a case history and perform the examination, including any needed tests. The following minimum scheduling intervals (i.e., time set aside for the individual, not the actual duration of the consultative examination) should be used.

- (1) Comprehensive general medical examination—at least 30 minutes;
- (2) Comprehensive musculoskeletal or neurological examination—at least 20 minutes;
- (3) Comprehensive psychiatric examination—at least 40 minutes;

(4) Psychological examination—at least 60 minutes (Additional time may be required depending on types of psychological tests administered); and

(5) All others—at least 30 minutes, or in accordance with accepted medical practices.

We recognize that actual practice will dictate that some examinations may require longer scheduling intervals depending on the circumstances in a particular situation. We also recognize that these minimum intervals may have to be adjusted to allow for those claimants that do not attend their scheduled examination. The purpose of these minimum scheduling timeframes is to ensure that such examinations are complete and that sufficient time is made available to obtain the information needed to make an accurate determination in your case. State agencies will monitor the scheduling of examinations (through their normal consultative examination oversight activities) to ensure that any overscheduling is avoided, as overscheduling may lead to examinations that are not thorough.

(b) *Report content.* The reported results of your medical history, examination, requested laboratory findings, discussions and conclusions must conform to accepted professional standards and practices in the medical field for a complete and competent examination. The facts in a particular case and the information and findings already reported in the medical and other evidence of record will dictate the extent of detail needed in the consultative examination report for that case. Thus, the detail and format for reporting the results of a purchased examination will vary depending upon the type of examination or testing requested. The reporting of information will differ from one type of examination to another when the requested examination relates to the performance of tests such as ventilatory function tests, treadmill exercise tests, or audiological tests. The medical report must be complete enough to help us determine the nature, severity, and duration of the impairment, and residual functional capacity. The report should reflect your statements of your symptoms, not simply the physician's or psychologist's statements or conclusions. The exam-

ining physician's or psychologist's report of the consultative examination should include the objective medical facts as well as observations and opinions.

(c) *Elements of a complete consultative examination.* A complete consultative examination is one which involves all the elements of a standard examination in the applicable medical specialty. When the report of a complete consultative examination is involved, the report should include the following elements:

- (1) Your major or chief complaint(s);
- (2) A detailed description, within the area of specialty of the examination, of the history of your major complaint(s);
- (3) A description, and disposition, of pertinent "positive" and "negative" detailed findings based on the history, examination and laboratory tests related to the major complaint(s), and any other abnormalities or lack thereof reported or found during examination or laboratory testing;

(4) The results of laboratory and other tests (e.g., X-rays) performed according to the requirements stated in the Listing of Impairments (see Appendix 1 of Subpart P of Part 404 of this Chapter);

(5) The diagnosis and prognosis for your impairment(s);

(6) A statement about what you can still do despite your impairment(s), unless the claim is based on statutory blindness. This statement should describe the opinion of the consultative physician or psychologist about your ability, despite your impairment(s), to do work-related activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling; and, in cases of mental impairment(s), the opinion of the consultative physician or psychologist about your ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers and work pressures in a work setting; and

(7) In addition, the consultative physician or psychologist will consider, and provide some explanation or comment on, your major complaint(s) and any other abnormalities found during the history and examination or reported from the laboratory tests. The

history, examination, evaluation of laboratory test results, and the conclusions will represent the information provided by the physician or psychologist who signs the report.

(d) *When a complete consultative examination is not required.* When the evidence we need does not require a complete consultative examination (for example, we need only a specific laboratory test result to complete the record), we may not require a report containing all of the elements in paragraph (c).

(e) *Signature requirements.* All consultative examination reports will be personally reviewed and signed by the physician or psychologist who actually performed the examination. This attests to the fact that the physician or psychologist doing the examination or testing is solely responsible for the report contents and for the conclusions, explanations or comments provided with respect to the history, examination and evaluation of laboratory test results. The signature of the examining physician or psychologist on a report annotated "not proofed" or "dictated but not read" is not acceptable. A rubber stamp signature of a physician or psychologist or the physician's or psychologist's signature entered by any other person is not acceptable.

[56 FR 36966, Aug. 1, 1991]

§416.919o When a properly signed consultative examination report has not been received.

If a consultative examination report is received unsigned or improperly signed we will take the following action.

(a) *When we will make determinations and decisions without a properly signed report.* We will make a determination or decision in the circumstances specified in paragraphs (a)(1) and (a)(2) of this section without waiting for a properly signed consultative examination report. After we have made the determination or decision, we will obtain a properly signed report and include it in the file unless the physician or psychologist who performed the original consultative examination has died.

(1) Continuous period of disability allowance with an onset date as alleged or earlier than alleged; or

(2) Continuance of disability.

(b) *When we will not make determinations and decisions without a properly signed report.* We will not use an unsigned or improperly signed consultative examination report to make the determinations or decisions specified in paragraphs (b)(1), (b)(2), (b)(3), and (b)(4) of this section. When we need a properly signed consultative examination report to make these determinations or decisions, we must obtain such a report. If the signature of the physician or psychologist who performed the original examination cannot be obtained because the physician or psychologist is out of the country for an extended period of time, on an extended vacation, seriously ill, deceased, or for any other reason, the consultative examination will be rescheduled with another physician or psychologist.

(1) Denial; or

(2) Cessation; or

(3) Allowance of disability which has ended; or

(4) Allowance with an onset date later than the filing date.

[56 FR 36967, Aug. 1, 1991]

§416.919p Reviewing reports of consultative examinations.

(a) We will review the report of the consultative examination to determine whether the specific information requested has been furnished. We will consider the following factors in reviewing the report:

(1) Whether the report provides evidence which serves as an adequate basis for decisionmaking in terms of the impairment it assesses;

(2) Whether the report is internally consistent; Whether all the diseases, impairments and complaints described in the history are adequately assessed and reported in the clinical findings; Whether the conclusions correlate the findings from your medical history, clinical examination and laboratory tests and explain all abnormalities;

(3) Whether the report is consistent with the other information available to us within the specialty of the examination requested; Whether the report fails to mention an important or relevant complaint within that specialty that is noted in other evidence in the

file (e.g., your blindness in one eye, amputations, pain, alcoholism, depression);

(4) Whether this is an adequate report of examination as compared to standards set out in the course of a medical education; and

(5) Whether the report is properly signed.

(b) If the report is inadequate or incomplete, we will contact the examining consultative physician or psychologist, give an explanation of our evidentiary needs, and ask that the physician or psychologist furnish the missing information or prepare a revised report.

(c) With your permission, or where the examination discloses new diagnostic information or test results that reveal potentially life-threatening situations, we will refer the consultative examination report to your treating physician or psychologist. When we refer the consultative examination report to your treating physician or psychologist without your permission, we will notify you that we have done so.

(d) We will perform ongoing special management studies on the quality of consultative examinations purchased from major medical sources and the appropriateness of the examinations authorized.

(e) We will take steps to ensure that consultative examinations are scheduled only with medical sources who have access to the equipment required to provide an adequate assessment and record of the existence and level of severity of your alleged impairments.

[56 FR 36967, Aug. 1, 1991]

§416.919q Conflict of interest.

All implications of possible conflict of interest between medical or psychological consultants and their medical or psychological practices will be avoided. Such consultants are not only those physicians and psychologists who work for us directly but are also those who do review and adjudication work in the State agencies. Physicians and psychologists who work for us directly as employees or under contract will not work concurrently for a State agency. Physicians and psychologists who do review work for us will not perform consultative examinations for us

without our prior approval. In such situations, the physician or psychologist will disassociate himself or herself from further involvement in the case and will not participate in the evaluation, decision, or appeal actions. In addition, neither they, nor any member of their families, will acquire or maintain, either directly or indirectly, any financial interest in a medical partnership, corporation, or similar relationship in which consultative examinations are provided. Sometimes physicians and psychologists who do review work for us will have prior knowledge of a case; for example, when the claimant was a patient. Where this is so, the physician or psychologist will not participate in the review or determination of the case. This does not preclude the physician or psychologist from submitting medical evidence based on treatment or examination of the claimant.

[56 FR 36967, Aug. 1, 1991]

AUTHORIZING AND MONITORING THE REFERRAL PROCESS

§416.919s Authorizing and monitoring the consultative examination.

(a) Day-to-day responsibility for the consultative examination process rests with the State agencies that make disability determinations for us.

(b) The State agency will maintain a good working relationship with the medical community in order to recruit sufficient numbers of physicians and other providers of medical services to ensure ready availability of consultative examination providers.

(c) Consistent with Federal and State laws, the State agency administrator will work to achieve appropriate rates of payment for purchased medical services.

(d) Each State agency will be responsible for comprehensive oversight management of its consultative examination program, with special emphasis on key providers.

(e) A key consultative examination provider is a provider that meets at least one of the following conditions:

(1) Any consultative examination provider with an estimated annual billing to the Social Security and Supplemental Security Income programs of at least \$100,000; or

(2) Any consultative examination provider with a practice of medicine, osteopathy, or psychology directed primarily towards evaluation examinations rather than the treatment of patients; or

(3) Any consultative examination provider that does not meet the above criteria, but is one of the top five consultative examination providers in the State by dollar volume, as evidenced by prior year data.

(f) State agencies have flexibility in managing their consultative examination programs, but at a minimum will provide:

(1) An ongoing active recruitment program for consultative examination providers;

(2) A process for orientation, training, and review of new consultative examination providers, with respect to SSA's program requirements involving consultative examination report content and not with respect to medical techniques;

(3) Procedures for control of scheduling consultative examinations;

(4) Procedures to ensure that close attention is given to specific evaluation issues involved in each case;

(5) Procedures to ensure that only required examinations and tests are authorized in accordance with the standards set forth in this subpart;

(6) Procedures for providing medical or supervisory approval for the authorization or purchase of consultative examinations and for additional tests or studies requested by consulting physicians and psychologists. This includes physician approval for the ordering of any diagnostic test or procedure where the question of significant risk to the claimant/beneficiary might be raised. See §416.919m.

(7) Procedures for the ongoing review of consultative examination results to ensure compliance with written guidelines;

(8) Procedures to encourage active participation by physicians and psychologists in the consultative examination oversight program;

(9) Procedures for handling complaints;

(10) Procedures for evaluating claimant reactions to key providers; and

(11) A program of systematic, onsite reviews of key providers that will include annual onsite reviews of such providers when claimants are present for examinations. This provision does not contemplate that such reviews will involve participation in the actual examinations but, rather, offer an opportunity to talk with claimants at the provider's site before and after the examination and to review the provider's overall operation.

(g) The State agencies will cooperate with us when we conduct monitoring activities in connection with their oversight management of their consultative examination programs.

[56 FR 36967, Aug. 1, 1991]

PROCEDURES TO MONITOR THE CONSULTATIVE EXAMINATION

§416.919f Consultative examination oversight.

(a) We will ensure that referrals for consultative examinations and purchases of consultative examinations are made in accordance with our policies. We will also monitor both the referral processes and the product of the consultative examinations obtained. This monitoring may include reviews by independent medical specialists under direct contract with SSA.

(b) Through our regional offices, we will undertake periodic comprehensive reviews of each State agency to evaluate each State's management of the consultative examination process. The review will involve visits to key providers, with State staff participating, including a program physician when the visit will deal with medical techniques or judgment, or factors that go to the core of medical professionalism.

(c) We will also perform ongoing special management studies of the quality of consultative examinations purchased from key providers and other sources and the appropriateness of the examinations authorized.

[56 FR 36968, Aug. 1, 1991]

EVALUATION OF DISABILITY

§416.920 Evaluation of disability of adults, in general.

(a) *Steps in evaluating disability.* We consider all evidence in your case

record when we make a determination or decision whether you are disabled. When you file a claim for Supplemental Security Income disability benefits and are age 18 or older, we use the following evaluation process. If you are doing substantial gainful activity, we will determine that you are not disabled. If you are not doing substantial gainful activity, we will first consider the effect of your physical or mental impairment; if you have more than one impairment, we will also consider the combined effect of your impairments. Your impairment(s) must be severe and meet the duration requirement before we can find you to be disabled. We follow a set order to determine whether you are disabled. We review any current work activity, the severity of your impairment(s), your residual functional capacity, your past work, and your age, education, and work experience. If we can find that you are disabled or not disabled at any point in the review, we do not review your claim further. Once you have been found eligible for Supplemental Security Income benefits based on disability, we follow a somewhat different order of evaluation to determine whether your eligibility continues, as explained in §416.994(f)(6).

(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 your age, education, and work experience.

(c) *You must have a severe impairment.* If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience.

(d) *When your impairment(s) meets or equals a listed impairment in appendix 1.* If you have an impairment(s) which meets the duration requirement and is listed in appendix 1 or is equal to a listed impairment(s), we will find you disabled without considering your age, education, and work experience.

(e) *Your impairment(s) must prevent you from doing past relevant work.* If we cannot make a decision based on your

current work activity or on medical facts alone, and you have a severe impairment(s), we then review your residual functional capacity and the physical and mental demands of the work you have done in the past. If you can still do this kind of work, we will find that you are not disabled.

(f) *Your impairment(s) must prevent you from doing other work.* (1) If you cannot do any work you have done in the past because you have a severe impairment(s), we will consider your residual functional capacity and your age, education, and past work experience to see if you can do other work. If you cannot, we will find you disabled.

(2) If you have only a marginal education, and long work experience (i.e., 35 years or more) where you only did arduous unskilled physical labor, and you can no longer do this kind of work, we use a different rule (see §416.962).

[50 FR 8728, Mar. 5, 1985; 50 FR 19164, May 7, 1985, as amended at 56 FR 5554, Feb. 11, 1991; 56 FR 36968, Aug. 1, 1991]

§416.920a Evaluation of mental impairments.

(a) *General.* The steps outlined in §416.920 apply to the evaluation of physical and mental impairments. In addition, in evaluating the severity of mental impairments for adults (persons age 18 and over) and in persons under age 18 when part A of the Listing of Impairments is used, a special procedure must be followed by us at each level of administrative review. Following this procedure will assist us in:

(1) Identifying additional evidence necessary for the determination of impairment severity;

(2) Considering and evaluating aspects of the mental disorder(s) relevant to your ability to work; and

(3) Organizing and presenting the findings in a clear, concise, and consistent manner.

(b) *Use of the procedure to record pertinent findings and rate the degree of functional loss.* (1) This procedure requires us to record the pertinent signs, symptoms, findings, functional limitations, and effects of treatment contained in your case record. This will assist us in determining if a mental impairment(s) exists. Whether or not a mental impairment(s) exists is decided in the

same way the question of a physical impairment is decided, i.e., the evidence must be carefully reviewed and conclusions supported by it. The mental status examination and psychiatric history will ordinarily provide the needed information. (See §416.908 for further information about what is needed to show an impairment.)

(2) If we determine that a mental impairment(s) exists, this procedure then requires us to indicate whether certain medical findings which have been found especially relevant to the ability to work are present or absent.

(3) The procedure then requires us to rate the degree of functional loss resulting from the impairment(s). Four areas of function considered by us as essential to work have been identified, and the degree of functional loss in those areas must be rated on a scale that ranges from no limitation to a level of severity which is incompatible with the ability to perform those work-related functions. For the first two areas (activities of daily living and social functioning), the rating of limitation must be done based upon the following five point scale: None, slight, moderate, marked, and extreme. For the third area (concentration, persistence or pace) the following five point scale must be used: Never, seldom, often, frequent, and constant. For the fourth area (deterioration or decompensation in work or work-like settings), the following four point scale must be used: Never, once or twice, repeated (three or more), and continual. The last two points for each of these scales represents a degree of limitation which is incompatible with the ability to perform the work-related function.

(c) *Use of the procedure to evaluate mental impairments.* Following the rating of the degree of functional loss resulting from the impairment, we must then determine the severity of the mental impairment(s).

(1) If the four areas considered by us as essential to work have been rated to indicate a degree of limitation as "none" or "slight" in the first and second areas, "never" or "seldom" in the third area, and "never" in the fourth area, we can generally conclude that the impairment is not severe, unless the evidence otherwise indicates there

is significant limitation of your mental ability to do basic work activities (see §416.921).

(2) If your mental impairment(s) is severe, we must then determine if it meets or equals a listed mental disorder. This is done by comparing our prior conclusions based on this procedure (i.e., the presence of certain medical findings considered by us as especially relevant to your ability to work and our rating of functional loss resulting from the mental impairment(s)) against the paragraph A and B criteria of the appropriate listed mental disorder(s). If we determine that paragraph C criteria will be used in lieu of paragraph B criteria (see listings 12.03 and 12.06), we will, by following this procedure, indicate on the document whether the evidence is sufficient to establish the presence or absence of the criteria. (See paragraph (d) of this section).

(3) If you have a severe impairment(s) but the impairment(s) neither meets nor equals the listings, we must then do a residual functional capacity assessment, unless you are claiming benefits as a disabled child.

(4) At all adjudicative levels we must, in each case, incorporate the pertinent findings and conclusions based on this procedure in our decision rationale. Our rationale must show the significant history, including examination, laboratory findings, and functional limitations that we considered in reaching conclusions about the severity of the mental impairment(s).

(d) *Preparation of the document.* A standard document outlining the steps of this procedure must be completed by us in each case at the initial, reconsideration, administrative law judge hearing, and Appeals Council levels (when the Appeals Council issues a decision).

(1) At the initial and reconsideration levels the standard document must be completed and signed by our medical consultant. At the administrative law judge hearing level, several options are available:

(i) The administrative law judge may complete the document without the assistance of a medical advisor;

(ii) The administrative law judge may call a medical advisor for assistance in preparing the document; or

(iii) Where new evidence is received that is not merely cumulative of evidence already in your case file or where the issue of a mental impairment arises for the first time at the administrative law judge hearing level, the administrative law judge may decide to remand the case to the State agency for completion of the document and a new determination. Remand may also be made in situations where the services of a medical advisor are determined necessary but unavailable to the 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

(The 416.924 Denes is important — lots of principles & basis underlying elements are repeated throughout and left in place)

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

(4) Use of judgment;

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

routine

at 56 FR

(2) Will need revision

§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 combination, 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) *Definition of comparable severity.* If you are a child, we will find you disabled if you are not engaging in substantial gainful activity and you have

same way the question of a physical impairment is decided, i.e., the evidence must be carefully reviewed and conclusions supported by it. The mental status examination and psychiatric history will ordinarily provide the needed information. (See §416.908 for further information about what is needed to show an impairment.)

(2) If we determine that a mental impairment(s) exists, this procedure then requires us to indicate whether certain medical findings which have been found especially relevant to the ability to work are present or absent.

(3) The procedure then requires us to rate the degree of functional loss resulting from the impairment(s). Four areas of function considered by us as essential to work have been identified, and the degree of functional loss in those areas must be rated on a scale that ranges from no limitation to a level of severity which is incompatible with the ability to perform those work-related functions. For the first two areas (activities of daily living and social functioning), the rating of limitation must be done based upon the following five point scale: None, slight, moderate, marked, and extreme. For the third area (concentration, persistence or pace) the following five point scale must be used: Never, seldom, often, frequent, and constant. For the fourth area (deterioration or decompensation in work or work-like settings), the following four point scale must be used: Never, once or twice, repeated (three or more), and continual. The last two points for each of these scales represents a degree of limitation which is incompatible with the ability to perform the work-related function.

(c) *Use of the procedure to evaluate mental impairments.* Following the rating of the degree of functional loss resulting from the impairment, we must then determine the severity of the mental impairment(s).

(1) If the four areas considered by us as essential to work have been rated to indicate a degree of limitation as "none" or "slight" in the first and second areas, "never" or "seldom" in the third area, and "never" in the fourth area, we can generally conclude that the impairment is not severe, unless the evidence otherwise indicates there

is significant limitation of your mental ability to do basic work activities (see §416.921).

(2) If your mental impairment(s) is severe, we must then determine if it meets or equals a listed mental disorder. This is done by comparing our prior conclusions based on this procedure (i.e., the presence of certain medical findings considered by us as especially relevant to your ability to work and our rating of functional loss resulting from the mental impairment(s)) against the paragraph A and B criteria of the appropriate listed mental disorder(s). If we determine that paragraph C criteria will be used in lieu of paragraph B criteria (see listings 12.03 and 12.06), we will, by following this procedure, indicate on the document whether the evidence is sufficient to establish the presence or absence of the criteria. (See paragraph (d) of this section).

(3) If you have a severe impairment(s) but the impairment(s) neither meets nor equals the listings, we must then do a residual functional capacity assessment, unless you are claiming benefits as a disabled child.

(4) At all adjudicative levels we must, in each case, incorporate the pertinent findings and conclusions based on this procedure in our decision rationale. Our rationale must show the significant history, including examination, laboratory findings, and functional limitations that we considered in reaching conclusions about the severity of the mental impairment(s).

(d) *Preparation of the document.* A standard document outlining the steps of this procedure must be completed by us in each case at the initial, reconsideration, administrative law judge hearing, and Appeals Council levels (when the Appeals Council issues a decision).

(1) At the initial and reconsideration levels the standard document must be completed and signed by our medical consultant. At the administrative law judge hearing level, several options are available:

(i) The administrative law judge may complete the document without the assistance of a medical advisor;

(ii) The administrative law judge may call a medical advisor for assistance in preparing the document; or

(iii) Where new evidence is received that is not merely cumulative of evidence already in your case file or where the issue of a mental impairment arises for the first time at the administrative law judge hearing level, the administrative law judge may decide to remand the case to the State agency for completion of the document and a new determination. Remand may also be made in situations where the services of a medical advisor are determined necessary but unavailable to the 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 combination, 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) *Definition of comparable severity.* If you are a child, we will find you disabled if you are not engaging in substantial gainful activity and you have

an impairment or combination of impairments that is of comparable severity to an impairment or combination of impairments that would disable an adult and which meets the duration requirement (see §416.909). By the term *comparable severity*, we mean that your physical or mental impairment(s) so limits your ability to function independently, appropriately, and effectively in an age-appropriate manner that your impairment(s) and the limitations resulting from it are comparable to those which would disable an adult. Specifically, your impairment(s) must substantially reduce your ability to—

(1) Grow, develop, or mature physically, mentally, or emotionally and, thus, to attain developmental milestones (see §416.924b(2)) at an age-appropriate rate; or

(2) Grow, develop, or mature physically, mentally, or emotionally and, thus, to engage in age-appropriate activities of daily living (see §416.924b(3)) in self-care, play and recreation, school and academics, community activities, vocational settings, peer relationships, or family life; or

(3) Acquire the skills needed to assume roles reasonably expected of adults (see §416.924b(4)).

(b) *Steps in evaluating disability.* We consider all 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 ability to function. We will also evaluate any limitations in your ability to function that result from your symptoms, including pain (see §416.929). When you file a claim, we use the evaluation process set forth in (c) through (f) 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 or equals in severity any impairment that is listed in appendix 1 of subpart P of part 404 of this chapter, in which case we will find you disabled. If you do not have such an impairment(s), we will do an individualized functional assessment and determine whether you are disabled. Once you have been found eligible for disability benefits, we follow a somewhat different procedure to determine whether your eligibility continues, as explained in §416.994a.

(c) *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.)

(d) *You must have a severe impairment(s).* If your impairment is a slight abnormality or a combination of slight abnormalities that causes no more than minimal limitation in your ability to function independently, appropriately, and effectively in an age-appropriate manner, we will find that you do not have a severe impairment and are, therefore, not disabled.

(e) *When your impairment(s) meets or equals a listed impairment in appendix 1.* The Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter is set at a level of severity that precludes any gainful activity or that is comparable in severity to an impairment that would preclude an adult from engaging in any gainful activity. Therefore, if you have an impairment(s) which meets the duration requirement and is listed in appendix 1, or is equal to a listed impairment, we will find you disabled. We will not deny your claim on the basis of a finding that your impairment(s) does not meet the requirements for any listed impairment or is not equal in severity to any of the impairments listed in appendix 1. We explain our rules for deciding whether an impairment meets a listing in §416.925. Our rules for how

we decide whether an impairment(s) equals a listing are set forth in §416.926a.

(f) *Your impairment(s) must be of comparable severity to an impairment(s) that would disable an adult.* When we determine that your impairment(s) is severe, but that it does not meet or equal in severity any listed impairment, we will assess the impact of your impairment(s) on your overall ability to function independently, appropriately, and effectively in an age-appropriate manner. We will use this individualized functional assessment to decide whether you have an impairment(s) of comparable severity to an impairment(s) that would prevent an adult from engaging in substantial gainful activity and, thus, to determine whether or not you are disabled. We will use the individualized functional assessment in the following manner:

(1) If:

(i) Our evaluation of all the evidence in your claim shows that your impairment(s) substantially reduces your physical or mental ability to function independently, appropriately, and effectively in an age-appropriate manner, and

(ii) Your impairment(s) meets the duration requirement, we will find you disabled.

(2) If we find that your impairment(s) does not substantially reduce your physical or mental ability to function independently, appropriately, and effectively in an age-appropriate manner, or if your impairment(s) does not meet the duration requirement, we will find that you are not disabled.

(g) *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.

[58 FR 47577, Sept. 9, 1993]

§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(d)) or whether you are disabled based on an individualized functional assessment (see §416.924(f)). 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 prevent a child from

functioning independently, appropriately, and effectively in an age-appropriate manner. 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 or combination of impairments with a listed impairment to determine whether you have an impairment(s) which equals 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) When we determine whether you have an impairment(s) which, though not meeting or equaling the listings, is of comparable severity to an impairment that would disable an adult, we will always consider the significance of your impairment(s) in relation to your age. We will consider the functions, behaviors, and activities that are appropriate to your age, and will evaluate the effect of your impairment(s), either alone or in conjunction with other relevant factors, on your ability to perform these functions, behaviors, and activities. (We explain how we do this individualized functional assessment in §§416.924d and 416.924e.)

(5) 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) *Age categories.* When we determine whether you are functioning independently, appropriately, and effectively in an age-appropriate manner, we will consider your age in the following categories:

(1) Newborn and young infants (birth to attainment of age 1).

(2) Older infants and toddlers (age 1 to attainment of age 3).

(3) Children (age 3 to attainment of age 18), considered according to the following subcategories:

(i) Preschool children (age 3 to attainment of age 6).

(ii) School-age children (age 6 to attainment of age 12).

(iii) Young adolescents (age 12 to attainment of age 16), and

(iv) Older adolescents (age 16 to attainment of age 18).

(c) *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(s) affects a child's ability to function independently, appropriately, and effectively in an age-appropriate manner. 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—(1) 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.

(1) 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).

(d) *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 which allow the child to compensate for the

impairment(s) and, thus, to function in an age-appropriate manner 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 independently, appropriately, and effectively in an age-appropriate manner as set forth in this section and §§416.924 and 416.924c through 416.924e.

(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.

(1) 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.

(1) 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 age-appropriate for them are those that are also age-appropriate for 18-year-olds, i.e., those that are needed to assume roles reasonably expected of adults. Older adolescents generally also share with the youngest adults the same abilities to adapt to work-related activities despite a severe impairment(s).

(1) By the age of adolescence, children have developed basic physical and mental 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 (d)(1) of this section, we also recognize that young and older adolescents may experience a variety of impairments with different effects on their ability to function in an age-appropriate manner. For instance, a child born with a degenerative disorder may experience a worsening of its effects as he or she grows older so that functioning is more limited for the older child than it is for a younger child with the same illness or disorder.)

(ii) Inasmuch as age-appropriate functioning for an older adolescent is also that of an 18-year-old young adult, the disability determination for an older adolescent must be consistent with the disability determination we would make for an 18-year-old person

having the same functional limitations.

[58 FR 47578, Sept. 9, 1993]

§416.924b Functioning in children.

(a) *General.* When we evaluate your functioning, we will consider all of your mental and physical limitations that result from your impairment(s). We will evaluate the extent to which you can engage in age-appropriate activities in an independent, appropriate, and effective manner and, when applicable, whether you can do these things on a sustained basis appropriate to your age.

(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 the most important 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 the most important indicators of functional limitations in children aged 3 to attainment 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 age-appropriate contexts, such as school, work, vocational programs, and organized activities. Ordinarily, inability to perform work-related activities is the most important indicator of impaired functioning in older adolescents, aged 16 to attainment of age 18.

(5) *Domains and behaviors.* The terms *developmental domains*, *functional domains*, and *behaviors*, which we use when we perform an individualized functional assessment, refer to broad areas of functioning that can be identified in infancy and traced throughout a child's growth and maturation into adulthood. The domains describe the child's major spheres of activity—i.e., physical, cognitive, communicative, social/ emotional, and personal/behavioral. In addition, there are certain areas of behavior that are applicable to specific age categories (i.e., responsiveness to stimuli; concentration, persistence, and pace). The domains and behaviors we use in these regulations are intended to encompass and reflect all the things that a child may do at any particular age, and are, therefore, intended to include all of a child's functioning. All the effects of a child's impairment(s) on daily functioning will be considered within these domains and behaviors. The presence of pain or other symptoms can adversely affect functioning in the domains or behaviors. In these regulations, the term *developmental domains* is generally used when we discuss the functioning of younger children, i.e., from birth to age 3; the term *functional domains* is generally used when we discuss older children and adolescents, i.e., from age 3 to age 18. (See §416.924d for descriptions of the various domains and behaviors as they pertain to the different age categories.)

[58 FR 47580, Sept. 9, 1993]

§416.924c Other factors we will consider.

(a) *General.* When we evaluate how you are able to function, 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 the effect of your impairment(s) on your functioning, 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 ability to function, and help us to assess your functioning within the domains and behaviors (see §416.924b(b)(5)). 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 of your overall ability to function. 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 can function independently, appropriately, and effectively in an age-appropriate manner, we will consider 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 overall functioning on a longitudinal basis, or whether your outpatient care (because of its frequency, effects on your functioning, or both) significantly interferes with your activities of daily living.

(c) *Effects of medication.* We will consider the effects of medication on your symptoms, signs, and laboratory findings, including your ability to function. 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 you have any functional limitations

which may nevertheless persist, 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 severe 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, and may be relatively free of obvious 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 ability to function in an age-appropriate manner 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 ability to function independently, appropriately, and effectively in an age-appropriate manner 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 ability to function, even though you may still have limitations in your ability to function in an age-appropriate manner (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 ability to function with an ad-

aptation, we will consider the degree to which the adaptation enables you to function independently, appropriately, and effectively in an age-appropriate manner.

(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 and continuous therapy, although intended to improve your functioning, may also interfere significantly with your opportunities to engage in, and sustain, age-appropriate activities. If you receive such therapy at school during a normal school day, it may or may not interfere significantly with your doing age-appropriate activities. If you must frequently interrupt your activities at school or at home for therapy, these interruptions may interfere with your development and age-appropriate functioning. When we determine whether you can function independently, appropriately, and effectively in an age-appropriate manner, we will consider the frequency of any multidisciplinary therapy that you must have, how long you have needed the therapy or will need the therapy, and the extent to which it interferes with your age-appropriate 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 ability to function. 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 ability to function independently, appropriately, and effectively in a regular classroom setting in an age-appropriate manner. 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

you
ap-
ge-
en-
er-
ive
out
of
he
re,
nt
usual
outcome of the treatment or intervention in your particular case.

These are the 2 subsections eliminated

↓

[58 FR 47581, Sept. 9, 1993]

§416.924d Individualized functional assessment for children.

(a) *General.* If your impairment(s) is severe, but does not meet or equal in severity any of the listings in appendix 1 of subpart P of part 404 of this chapter, we will do an individualized functional assessment to determine whether you have an impairment or combination of impairments which would nevertheless be of comparable severity to an impairment(s) that would disable an adult. When we assess your functioning, we will consider all information in your case record that can help us determine the impact 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, your ability to perform age-appropriate daily activities, and other relevant factors. (See §§416.924a through 416.924c.) We will assess the extent to which you are able to function independently, appropriately, and effectively in an age-appropriate manner despite your impairment(s), and use this assessment to determine whether you are disabled.

(b) *Responsibility for individualized functional assessment.* 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 the individualized functional assessment. This assessment is based on all of the evidence we have, from all sources, including any statements regarding what you can still do that have been provided by treating or examining physicians, consultative physicians, or any other medical or psychological consultant designated by the Secretary. For cases in the disability hearing process, the responsibility for the individualized functional assessment 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 hearing or Appeals Council level, the responsibility for the individualized functional assessment rests with the Administrative Law Judge or Appeals Council.

(c) *Domains of development or functioning.* The following are the domains of development or functioning, or specific behaviors, that may be addressed in an individualized functional assessment:

- (1) Cognition;
- (2) Communication;
- (3) Motor abilities;
- (4) Social abilities;
- (5) Responsiveness to stimuli (in children from birth to the attainment of age 1);
- (6) Personal/behavioral patterns (in children from age 1 to the attainment of age 18); and
- (7) Concentration, persistence, and pace in task completion (in children from age 3 to the attainment of age 18).

(d) *How we use the domains.* (1) When we do an individualized functional assessment, we will consider the extent of your impairment-related limitations in the domains or behaviors affected by your impairment(s), and how well you are able to do age-appropriate activities despite your limitations. We will also consider how your impairment(s) in one domain affects your development or functioning in other domains.

which may nevertheless persist, 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 severe 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, and may be relatively free of obvious 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 ability to function in an age-appropriate manner 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 ability to function independently, appropriately, and effectively in an age-appropriate manner 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 ability to function, even though you may still have limitations in your ability to function in an age-appropriate manner (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 ability to function with an ad-

aptation, we will consider the degree to which the adaptation enables you to function independently, appropriately, and effectively in an age-appropriate manner.

(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 and continuous therapy, although intended to improve your functioning, may also interfere significantly with your opportunities to engage in, and sustain, age-appropriate activities. If you receive such therapy at school during a normal school day, it may or may not interfere significantly with your doing age-appropriate activities. If you must frequently interrupt your activities at school or at home for therapy, these interruptions may interfere with your development and age-appropriate functioning. When we determine whether you can function independently, appropriately, and effectively in an age-appropriate manner, we will consider the frequency of any multidisciplinary therapy that you must have, how long you have needed the therapy or will need the therapy, and the extent to which it interferes with your age-appropriate 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 ability to function. 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 ability to function independently, appropriately, and effectively in a regular classroom setting in an age-appropriate manner. 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 able to function independently, appropriately, and effectively in an age-appropriate manner.

(h) *Treatment and intervention, in general.* With adequate treatment or intervention, some children not only have their symptoms and signs reduced, but also return to or achieve a level of functioning that is consistent with the norms for their age. 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.

[58 FR 47581, Sept. 9, 1993]

§416.924d Individualized functional assessment for children.

(a) *General.* If your impairment(s) is severe, but does not meet or equal in severity any of the listings in appendix 1 of subpart P of part 404 of this chapter, we will do an individualized functional assessment to determine whether you have an impairment or combination of impairments which would nevertheless be of comparable severity to an impairment(s) that would disable an adult. When we assess your functioning, we will consider all information in your case record that can help us determine the impact 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, your ability to perform age-appropriate daily activities, and other relevant factors. (See §§416.924a through 416.924c.) We will assess the extent to which you are able to function independently, appropriately, and effectively in an age-appropriate manner despite your impairment(s), and use this assessment to determine whether you are disabled.

(b) *Responsibility for individualized functional assessment.* 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 the individualized functional assessment. This assessment is based on all of the evidence we have, from all sources, including any statements regarding what you can still do that have been provided by treating or examining physicians, consultative physicians, or any other medical or psychological consultant designated by the Secretary. For cases in the disability hearing process, the responsibility for the individualized functional assessment 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 hearing or Appeals Council level, the responsibility for the individualized functional assessment rests with the Administrative Law Judge or Appeals Council.

(c) *Domains of development or functioning.* The following are the domains of development or functioning, or specific behaviors, that may be addressed in an individualized functional assessment:

- (1) Cognition;
- (2) Communication;
- (3) Motor abilities;
- (4) Social abilities;
- (5) Responsiveness to stimuli (in children from birth to the attainment of age 1);
- (6) Personal/behavioral patterns (in children from age 1 to the attainment of age 18); and
- (7) Concentration, persistence, and pace in task completion (in children from age 3 to the attainment of age 18).

(d) *How we use the domains.* (1) When we do an individualized functional assessment, we will consider the extent of your impairment-related limitations in the domains or behaviors affected by your impairment(s), and how well you are able to do age-appropriate activities despite your limitations. We will also consider how your impairment(s) in one domain affects your development or functioning in other domains.

(2) We will consider whether any help or intervention that you need from others to enable you to do any particular activity is appropriate to your age.

(3) The guidelines in paragraphs (e) through (j) of this section describe, in terms of the age categories outlined in §416.924a(b), the domains of development or functioning and the behaviors used in doing an individualized functional assessment, and the general kinds of age-related activities that may be affected by your impairment(s). (See §416.924a(a)(5) for guidelines on age and a child's ability to be tested, and §416.924e for guidelines for determining disability using an individualized functional assessment.)

(e) *Newborns and young infants (birth to attainment of age 1).* Children in this age group are evaluated in an individualized functional assessment in terms of four developmental domains and an area of behavior important to newborns and young infants.

(1) Cognitive development, e.g., your ability to begin to organize and regulate how you feel and the ways you react to your environment;

(2) Communicative development (includes speech and language), e.g., your ability to communicate spontaneously and with intention through visual, motor, and vocal exchanges;

(3) Motor development (includes gross and fine motor skills), e.g., your ability to explore your environment by moving your body, and your ability to manipulate your environment by using your hands;

(4) Social development, e.g., your ability to form patterns of self-regulation, to form and maintain intimate relationships with your primary caregivers, and to exchange a variety of age-appropriate emotional cues and begin to organize intentional behavior;

(5) Responsiveness to stimuli, i.e., your ability to respond appropriately to stimulation, e.g., visual, auditory, and tactile.

(f) *Older infants and toddlers (age 1 to attainment of age 3).* Children in this age group are evaluated in an individualized functional assessment in terms of five developmental domains.

(1) Cognitive development, e.g., your ability to understand by responding to increasingly complex requests, instruc-

tions or questions, by referring to yourself and things around you by pointing and eventually by naming, and by copying things or imitating actions shown to you by others, and by knowing what you want, as illustrated, for example, by searching for a toy or asking for a special food;

(2) Communicative development (includes speech and language), e.g., your ability to communicate your wishes or needs by using gestures or pretend play, and by understanding, imitating, and using an increasing number of intelligible words, and eventually forming two-to-four word sentences in spontaneous, interactive conversation;

(3) Motor development (includes gross and fine motor skills), e.g., your ability to move in your environment using your body with steadily increasing dexterity and independence from support by others, and your ability to use your hands to do something that you want or get something that you need;

(4) Social development, e.g., your ability to express normal dependence upon, and intimacy with, your primary caregivers, as well as increasing independence from them, to initiate and respond to a variety of age-appropriate emotional cues, and to regulate and organize emotions and behaviors;

(5) Personal/behavioral development, e.g., your ability to help yourself and to cooperate with others in taking care of your personal needs, in adapting to your environment, in responding to limits, and in learning new skills.

(g) *Preschool children (age 3 to attainment of age 6).* Children in this age group are evaluated in an individualized functional assessment in terms of five developmental domains and an area of behavior important to preschool children.

(1) Cognitive development, e.g., your ability to understand, to reason and to solve problems, and to use acquired knowledge and concepts;

(2) Communicative development (includes speech and language), e.g., your ability to communicate by telling, requesting, predicting, and relating information, by following and giving directions, by describing actions and functions, and by expressing your needs, feelings, and preferences in a

spontaneous, interactive, and increasingly intelligible manner, using simple sentences in grammatical form;

(3) Motor development (includes gross and fine motor skills), e.g., your ability to move and use your arms and legs in increasingly more intricate and coordinated activity, and your ability to use your hands with increasing coordination to manipulate small objects during play.

(4) Social development, e.g., your ability to initiate age-appropriate social exchanges and to respond to your social environment through appropriate and increasingly complex interpersonal behaviors, such as showing affection, sharing, cooperating, helping, and relating to other children as individuals or as a group;

(5) Personal/behavioral development, e.g., your ability to help yourself and to cooperate with others in taking care of your personal needs, in adapting to your environment, in responding to limits, and in learning new skills;

(6) Concentration, persistence, and pace, e.g., your ability to engage in an activity, such as dressing or playing, and to sustain the activity for a period of time and at a pace appropriate to your age.

(h) *School-age children (age 6 to attainment of age 12).* Children in this age group are evaluated in an individualized functional assessment in terms of five functional domains and an area of behavior important to school-age children.

(1) Cognitive function, e.g., your ability to progress in learning the skills involved in reading, writing, and mathematics;

(2) Communicative function (includes speech and language), e.g., your ability to communicate pragmatically (i.e., to meet your needs) and conversationally (i.e., 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;

(3) Motor function (includes gross and fine motor skills), e.g., your ability to engage in the physical activities involved in play and physical education, appropriate to your age;

(4) Social function, e.g., your ability to play alone, or with another child, or

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 groups (e.g., siblings, parents or caregivers, peers, teachers, school classes, neighborhood groups);

(5) Personal/behavioral function, e.g., your ability to help yourself and to cooperate with others in taking care of your personal needs and safety; to respond appropriately to authority and school rules; to manifest a sense of responsibility for yourself and respect for others; to adapt to your environment; and to learn new skills;

(6) Concentration, persistence, and pace, e.g., your ability to engage in an activity, such as playing or reading, and to sustain the activity for a period of time and at a pace appropriate to your age.

(i) *Young adolescents (age 12 to attainment of age 16).* Children in this age group are evaluated in an individualized functional assessment in terms of five functional domains and an area of behavior important to young adolescents.

(1) Cognitive function, e.g., your ability to progress in applying the skills involved in reading, writing, and mathematics; your conceptual growth, reasoning and problem-solving abilities;

(2) Communicative function (includes speech and language), e.g., your ability to communicate pragmatically (i.e., to meet your needs) and to converse spontaneously and interactively, expressing complex thoughts with increasing vocabulary in all communication environments (e.g., home, classroom, playground, extra-curricular activities, job) and with all communication partners (e.g., parents or caregivers, siblings, peers, school classes, teachers, other authority figures);

(3) Motor function (includes gross and fine motor skills), e.g., your ability to engage in the physical activities involved in physical education, sports, and social events appropriate to your age;

(4) Social function, e.g., your ability 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;

(5) Personal/behavioral function, e.g., your ability to help yourself in taking care of your personal needs and safety, to respond appropriately to authority and school rules, to manifest a sense of responsibility for yourself and respect for others; to adapt to your environment; and to learn new skills;

(6) Concentration, persistence, and pace, e.g., your ability to engage in an activity, such as studying or practicing a sport, and to sustain the activity for a period of time and at a pace appropriate to your age.

(j) *Older adolescents (age 16 to attainment of age 18).* (1) Descriptive information about your activities of daily living will tell us about the nature and age-appropriateness of your activities with respect to your cognitive functioning, communicative functioning, motor functioning, social functioning, personal/behavioral functioning, and your concentration, persistence, and pace in school or work-related activities. (See §416.924d(1) (1) through (6) for a description of these domains and behaviors.)

(2) As you approach adulthood (i.e., beginning at about age 16), we will consider some of your school activities as evidence of your ability to function in a job setting. For example, we will consider your ability to understand, carry out, and remember simple instructions and work-like procedures in the classroom as evidence of your ability to do these things in a job. We will consider your ability to communicate spontaneously, interactively, and age-appropriately in the classroom as evidence of your ability to do this in a job. We will consider your ability to maintain attention for extended periods of time and to sustain an ordinary daily routine without special supervision as evidence of your ability to do these things in a job. We will consider your ability to deal with authority figures and to follow directions in school, responding appropriately to correction or criticism, as evidence of your ability to deal with supervision on a job. We will consider your ability to interact with

peers in school, school-related activities, and other age-appropriate environments as evidence of your ability to relate to co-workers in a job. We will consider your ability to regulate your mood and behavior in various school settings as evidence of your ability to deal with change in a work setting. We will consider your ability to engage in physical activities both in and out of school as evidence of your ability to perform the physical demands of work. We will also consider whether you have acquired any skills from specific vocational education and whether you have pursued any part-time or stay-in-school employment.

(3) If you are working or have worked, we will evaluate such things as: The physical activities in which you are engaged on the job; the regularity and punctuality of your attendance; your ability to follow directions and deal with supervisors; and your ability to work independently and to deal with others in your job.

[58 FR 47582, Sept. 9, 1993]

§416.924e Guidelines for determining disability using the individualized functional assessment.

(a) *General.* The guidelines in this section are provided as a framework for deciding whether a child who has a severe impairment(s) that does not meet or equal the listings nevertheless has an impairment(s) that is of comparable severity to one that would disable an adult, and is, therefore, disabled. The guidelines illustrate a level of impairment severity that is generally, though not invariably, sufficient to establish comparable severity; i.e., to establish that there is an impairment or combination of impairments that substantially reduces your ability to function independently, appropriately, and effectively in an age-appropriate manner. The examples in this section are only guidelines to illustrate severity and are not all-inclusive rules. The determination of your claim is based on all relevant evidence in the case record, using the principles and guidance in §§416.924 through 416.924d on a case-by-case basis.

(b) *How we describe functional limitations.* The terms used in this section to describe functional severity of both

physical and mental impairments employ as a frame of reference the terminology and definitions in the childhood mental listings in 112.00 of the Listing of Impairments in appendix 1 to subpart P of part 404 of this chapter. Hence, the examples of "moderate" and other limitations are derived from a comparison with the "marked" levels of functional limitation in the listings. As in those listings, "marked" and "moderate" are not the number of activities or functions which are restricted, but the overall degree of restriction or combination of restrictions in a domain or behavior. A marked or moderate limitation may arise when several activities or functions in a domain or behavior are impaired, or even when only one is impaired.

(1) If you are a younger child, from birth to the attainment of age 3, your functional limitations will generally be described in the examples in terms of a developmental delay, or the fraction or percentage of your chronological age that represents the levels of your functioning; e.g., three-fourths of chronological age. If you are functioning in one of the domains or behaviors described for your age in §416.924d at more than one-half, but not more than two-thirds, of your chronological age, you are said to have a marked impairment in that domain or behavior. If you are functioning in one of the domains or behaviors described for your age in §416.924d at more than two-thirds, but not more than three-fourths of your chronological age, we describe your impairment in that domain or behavior as moderate.

(2) If you are an older child or young adolescent, from age 3 to the attainment of age 16, your impairment(s) will generally be described in the examples in terms of specific kinds of age-appropriate activities, functional abilities, or abnormal behaviors. Although it is sometimes appropriate to evaluate severity in this age group in the same terms as are used in paragraph (b)(1) of this section, which describes moderate limitation of functioning in terms of a level that is more than two-thirds but not more than three-fourths of a child's chronological age, the older a child becomes, the less precise are the means of determining this kind of pro-

file. The spectrum of limitations that may constitute "moderate" impairment in this age group ranges from limitations that may be close to the "marked" level in severity to limitations that may be close to the "mild" level and, thus, considerably less limiting. Use of the examples as guides in the evaluation of older children and young adolescents, therefore, requires careful evaluation and judgment in each individual case, taking into account the child's age (as explained in §416.924a) and all other relevant factors described in §§416.924 through 416.924d.

(3) If you are an older adolescent, aged 16 to the attainment of age 18, functional limitations are generally evaluated in terms of physical and mental activities that are the same as, or similar to, activities of young adults. Hence, the guidance and examples in paragraph (d) of this section focus on physical abilities (exertional and nonexertional) and mental abilities associated with work activities, as described in §§416.921, 416.945, 416.967, 416.968, and 416.969a. However, assessment of an older adolescent's abilities and limitations is to be made in an age-appropriate context, as demonstrated by performance in school, work, and other relevant settings.

(c) *How we evaluate children from birth to attainment of age 16—(1) Young children (birth to attainment of age 3).* If you are a newborn or young infant (birth to the attainment of age 1), we evaluate the severity of your impairment(s) with respect to four developmental domains (cognitive, communicative, motor, and social development) and your responsiveness to stimuli. If you are an older infant or toddler (age 1 to the attainment of age 3), we evaluate the severity of your impairment(s) with respect to five developmental domains (cognitive, communicative, motor, social, and personal/behavioral development). (See §416.924d(e) and (f) for descriptions of the domains and behaviors appropriate to each age group.) Our evaluation of severity is based on comparison with the descriptors of functional severity in Listings 112.02-112.12 for childhood mental disorders: If you achieve development of only one-half or less of your chronological age in a single domain, or of only two-thirds

or less of your chronological age in two domains, your limitations are at listing-level severity. Examples of when we will generally find comparable severity (as defined in paragraph (a) of this section) and, thus, find you disabled include the following situations described in paragraphs (c)(1) (i) through (ii) of this section. However, the guidance provided by these examples for evaluating young children is not intended to be a standard by which all cases must be judged. Each case must be evaluated on its own merits using the principles and guidelines of all the regulations addressing childhood disability.

(i) You are functioning in one domain (e.g., motor development) at a level that is more than one-half, but not more than two-thirds of the normal age-appropriate level for a child your age and you are functioning in another domain (e.g., communicative) at a level that is more than two-thirds but not more than three-fourths of the normal age-appropriate level for a child your age; or

(ii) You are functioning in three domains (e.g., cognitive, motor, and social development) at a level that is more than two-thirds, but not more than three-fourths of the normal age-appropriate level for a child your age.

(2) *Older children and young adolescents, age 3 to attainment of age 16.* If you are in this age group, we evaluate the severity of your impairment(s) with respect to five functional domains (cognitive, communicative, motor, social, and personal/behavioral function), and your concentration, persistence, and pace in the completion of age-appropriate tasks. (See §416.924d(g) through (i) for descriptions of the domains and behaviors appropriate to this age group.) The level of severity illustrating the term "moderate," and the overall level of disability at less than the listing level, are based on comparison with the listing-level requirement for marked impairment in two domains, as described in 112.00C of the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter. In the case of preschoolers (age 3 to the attainment of age 6), it may be appropriate to evaluate the level of severity in terms of developmental age,

as in younger children. Examples of when we will generally find comparable severity (as defined in paragraph (a) of this section) and, thus, find you disabled include the following situations described in paragraphs (c)(2) (i) through (ii) of this section. However, the guidance provided by these examples for evaluating older children and young adolescents is not intended to be a standard by which all cases must be judged. Each case must be evaluated on its own merits using the principles and guidelines of all the regulations addressing childhood disability.

(i) You are functioning at the marked level in one domain or behavior (e.g., in the domain of social functioning, you are generally unable to maintain age-appropriate relationships with peers and adults, with frequent serious conflicts with your family, classmates, and teachers; or in the domain of motor functioning, your range of motion in your elbows, wrists, and fingers is limited by less than 50 percent and you have difficulty writing, typing, picking up and handling small objects, carrying, reaching, and engaging in physical activities which rely heavily on the use of the upper extremities), and you are functioning at the moderate level in another domain or behavior (e.g., in the domain of personal/behavioral functioning, you are frequently unable to perform self-care activities independently); or

(ii) You are functioning at the moderate level in three areas (e.g., in the domain of cognitive functioning, you have a valid full scale IQ of 74; in the domain of social functioning you have limited age-appropriate relationships with peers and adults, with occasional serious conflicts with family, classmates, teachers, and others; and with respect to the behavior of concentration, persistence and pace, you are frequently unable to complete age-appropriate complex tasks, and occasionally unable to perform simple age-appropriate tasks adequately).

(d) *How we evaluate older adolescents, from age 16 to attainment of age 18—(1) General.* As we explain in §416.924d(j), children aged 16 to 18 are closely approaching adulthood and can be evaluated in terms that are the same as, or

similar to, those used for the evaluation of the youngest adults. Children in this age range who do not have impairment-related limitations are ordinarily expected to be able to do the kinds of physical and mental activities expected of individuals who are at least 18 years old.

(i) The discussions in this section are predicated on the foregoing principles. They describe limitations of physical and mental functions that are associated with, or related to, functions in the workplace, as demonstrated by a child's performance of age-appropriate activities in age-appropriate context, such as school, part-time or full-time work, vocational programs, and organized activities. (See also §416.924d(j).)

(ii) As in the examples for younger children, the guidance for evaluating older adolescents is not intended to be a standard by which all cases must be judged. Each case must be evaluated on its own merits using the principles and guidelines of all of the regulations addressing childhood disability.

(2) *Mental functions.* Based on the profile of your activities and functioning in the relevant domains and behavior of cognition, communication, social functioning, personal/behavioral functioning, and your concentration, persistence, and pace in age-appropriate activities, we will consider your mental capacities to perform on a sustained basis (i.e., 8 hours a day, 5 days a week) the general kinds of mental activities that we evaluate for adults. We will consider such things as your ability to understand, carry out, and remember simple instructions; to maintain attention for extended periods of time; to use judgment; to make simple decisions; to take necessary safety precautions; to respond appropriately to supervision and peers (e.g., by being able to accept instructions and criticism, by not requiring special supervision, and by not being unduly distracted by your peers or unduly distracted to them in a school or work setting); and dealing with changes in your routine school or work setting. (See also, §416.924d(j).)

(3) *Physical functions.* Based on the profile of your activities in the relevant domain of motor functioning, and your concentration, persistence, and pace in age-appropriate activities, we will consider your physical capacity to perform on a sustained basis (i.e., 8 hours a day, 5 days a week) the types and ranges of exertional and nonexertional activities that we evaluate for adults; e.g., sitting, standing, walking, lifting, carrying, pushing, pulling, reaching, handling, manipulating, seeing, hearing, and speaking. (See also, §416.924d(j).)

(4) *Evaluation.* If an individualized functional assessment shows that you experience a substantial loss or deficit of capacity to perform the age-appropriate mental or physical activities described, we will find that your impairment(s) seriously interferes with your ability to function independently, appropriately, and effectively in an age-appropriate manner, and that it has substantially reduced your ability to acquire the skills needed to assume roles reasonably expected of adults. Therefore, we will conclude that you have an impairment(s) that is comparable in severity to an impairment that would disable an adult, and that you are disabled.

(i) The term "substantial loss or deficit" is not a precise number, percentage, or quantitative measure.

(ii) *Substantial loss or deficit* means that you are unable to meet the basic physical demands of at least sedentary work (as defined in §416.967(a)); or you are unable to meet the basic mental demands of at least unskilled work (as defined in §416.968(a)); or that you have an impairment(s) that would severely limit the potential occupational base of a person age 18 through 45 and that would justify a finding of inability to perform other work even for a person with favorable age, education, and work experience (see §§416.969, 416.969a, and appendix 2 to subpart P of part 404 of this chapter).

[58 FR 47584, Sept. 9, 1993]

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 which are considered severe enough to prevent a person from doing any gainful activity. 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.

(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) *Addition 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 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]

§416.926 Medical equivalence for adults.

(a) *How medical equivalence is determined.* We will decide that your impairment(s) is medically equivalent to a listed impairment in appendix 1 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 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 is a person by whom we determine whether your impairment(s) is medically equivalent to a listed impairment. (See §416.1016.)

Current medical functional equivalence Standard (equivalence to listings)

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; 66 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.

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 which are considered severe enough to prevent a person from doing any gainful activity. 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.

(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 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]

§416.926 Medical equivalence for adults.

(a) *How medical equivalence is determined.* We will decide that your impairment(s) is medically equivalent to a listed impairment in appendix 1 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 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.

(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 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 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

detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed below, as well as the factors in paragraphs (d) (3) through (5) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

(i) Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(ii) Nature and extent of the treatment relationship. Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reason-

able knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) *Supportability.* The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) *Consistency.* Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) *Specialization.* We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) *Other factors.* When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion.

(e) *Medical source opinions on issues reserved to the Secretary.*

(1) Opinions that you are disabled. We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled.

(2) Other opinions on issues reserved to the Secretary. We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of

your impairment(s). Although we consider opinions from treating and examining sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in Appendix 1 to subpart P of part 404 of this chapter, your residual functional capacity (see §§416.945 and 416.946), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Secretary. We will not give any special significance to the source of the opinion on these issues.

(f) *Opinions of nonexamining medical and psychological consultants and other nonexamining physicians and psychologists.* We consider all evidence from nonexamining physicians and psychologists to be opinion evidence. When we consider the opinions of nonexamining sources on the nature and severity of your impairments, we apply the rules set forth in paragraphs (a) through (e) of this section. In addition, the following rules apply to State agency medical and psychological consultants, and to medical advisors we consult in connection with administrative law judge hearings and Appeals Council review.

(1) At the initial and reconsideration steps in the administrative review process, except in disability hearings, State agency medical and psychological consultants are members of the teams that make the determinations of disability. A State agency medical or psychological consultant will consider the evidence in your case record and make findings of fact about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or equals the requirements for any impairment listed in Appendix 1 to subpart P of part 404 of this chapter, and your residual functional capacity. These administrative findings of fact are based on the evidence in your case record but are not themselves evidence at these steps.

(2) Administrative law judges are responsible for reviewing the evidence and making findings of fact and conclusions of law. Administrative law judges are not bound by any findings made by State agency medical or psychological

consultants. However, these findings are considered at the hearing level. See §416.912(b)(6). When administrative law judges consider these findings, they will evaluate them using the rules set forth in paragraphs (a) through (e) of this section. Also, administrative law judges may ask for and consider the opinions of medical advisors on the nature and severity of your impairment(s) and whether your impairment(s) equals the requirements of any listed impairment in appendix 1 to subpart P of part 404 of this chapter.

(3) When the Appeals Council makes a decision, it will follow the same rules for considering opinion evidence as administrative law judges follow.

[56 FR 36968, Aug. 1, 1991]

§416.928 Symptoms, signs, and laboratory findings.

Medical findings consist of symptoms, signs, and laboratory findings:

(a) *Symptoms* are your own description of your physical or mental impairment. If you are a child under age 18 and are unable to adequately describe your symptom(s), we will accept as a statement of this symptom(s) the description given by the person who is most familiar with you, such as a parent, other relative, or guardian. Your statements (or those of another person) alone, however, are not enough to establish that there is a physical or mental impairment.

(b) *Signs* are anatomical, physiological, or psychological abnormalities which can be observed, apart from your statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena which indicate specific abnormalities of behavior, affect, thought, memory, orientation and contact with reality. They must also be shown by observable facts that can be medically described and evaluated.

(c) *Laboratory findings* are anatomical, physiological, or psychological phenomena which can be shown by the use of a medically acceptable laboratory diagnostic techniques. Some of these diagnostic techniques include chemical tests, electrophysiological studies (electrocardiogram, electroencephalogram, etc.),

roentgenological studies (X-rays), and psychological tests.

[45 FR 55621, Aug. 20, 1980, as amended at 58 FR 47586, Sept. 9, 1993]

§416.929 How we evaluate symptoms, including pain.

(a) *General.* In determining whether you are disabled, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with the objective medical evidence, and other evidence. By objective medical evidence, we mean medical signs and laboratory findings as defined in §416.928 (b) and (c). By other evidence, we mean the kinds of evidence described in §§416.912(b) (2) through (6) and 416.913 (b) (1), (4), and (5) and (e). These include statements or reports from you, your treating or examining physician or psychologist, and others about your medical history, diagnosis, prescribed treatment, daily activities, efforts to work, and any other evidence showing how your impairment(s) and any related symptoms affect your ability to work (or if you are a child, to function independently, appropriately, and effectively in an age-appropriate manner). We will consider all of your statements about your symptoms, such as pain, and any description you, your physician, your psychologist, or other persons may provide about how the symptoms affect your activities of daily living and your ability to work (or if you are a child, to function independently, appropriately, and effectively in an age-appropriate manner). However, statements about your pain or other symptoms will not alone establish that you are disabled; there must be medical signs and laboratory findings which show that you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In evaluating the intensity and persistence of your symptoms, including pain, we will

consider all of the available evidence, including your medical history, the medical signs and laboratory findings and statements about how your symptoms affect you. (Section 416.927 explains how we consider opinions of your treating source and other medical opinions on the existence and severity of your symptoms, such as pain.) We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work (or if you are a child, to function independently, appropriately, and effectively in an age-appropriate manner).

(b) *Need for medically determinable impairment that could reasonably be expected to produce your symptoms, such as pain.* Your symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, will not be found to affect your ability to do basic work activities unless medical signs or laboratory findings show that a medically determinable impairment(s) is present. Medical signs and laboratory findings, established by medically acceptable clinical or laboratory diagnostic techniques, must show the existence of a medical impairment(s) which results from anatomical, physiological, or psychological abnormalities and which could reasonably be expected to produce the pain or other symptoms alleged. At the initial or reconsideration step in the administrative review process (except in disability hearings), a State agency medical or psychological consultant (or other medical or psychological consultant designated by the Secretary) directly participates in determining whether your medically determinable impairment(s) could reasonably be expected to produce your alleged symptoms. In the disability hearing process, a medical or psychological consultant may provide an advisory assessment to assist a disability hearing officer in determining whether your impairment(s) could reasonably be expected to produce your alleged symptoms. At the administrative law judge hearing or Appeals Council level, the administrative law judge or the Appeals Council

may ask for and consider the opinion of a medical advisor concerning whether your impairment(s) could reasonably be expected to produce your alleged symptoms. The finding that your impairment(s) could reasonably be expected to produce your pain or other symptoms does not involve a determination as to the intensity, persistence, or functionally limiting effects of your symptoms. We will develop evidence regarding the possibility of a medically determinable mental impairment when we have information to suggest that such an impairment exists, and you allege pain or other symptoms but the medical signs and laboratory findings do not substantiate any physical impairment(s) capable of producing the pain or other symptoms.

(c) *Evaluating the intensity and persistence of your symptoms, such as pain, and determining the extent to which your symptoms limit your capacity for work or for functioning in an age-appropriate manner—(1) General.* When the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain, we must then evaluate the intensity and persistence of your symptoms so that we can determine how your symptoms limit your capacity for work. In evaluating the intensity and persistence of your symptoms, we consider all of the available evidence, including your medical history, the medical signs and laboratory findings, and statements from you, your treating or examining physician or psychologist, or other persons about how your symptoms affect you. We also consider the medical opinions of your treating source and other medical opinions as explained in §416.927. Paragraphs (c)(2) through (c)(4) of this section explain further how we evaluate the intensity and persistence of your symptoms and how we determine the extent to which your symptoms limit your capacity for work (or if you are a child, to function independently, appropriately, and effectively in an age-appropriate manner), when the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be

expected to produce your symptoms, such as pain.

(2) *Consideration of objective medical evidence.* Objective medical evidence is evidence obtained from the application of medically acceptable clinical and laboratory diagnostic techniques, such as evidence of reduced joint motion, muscle spasm, sensory deficit or motor disruption. Objective medical evidence of this type is a useful indicator to assist us in making reasonable conclusions about the intensity and persistence of your symptoms and the effect those symptoms, such as pain, may have on your ability to work. We must always attempt to obtain objective medical evidence and, when it is obtained, we will consider it in reaching a conclusion as to whether you are disabled. However, we will not reject your statements about the intensity and persistence of your pain or other symptoms or about the effect your symptoms have on your ability to work (or if you are a child, to function independently, appropriately, and effectively in an age-appropriate manner) solely because the available objective medical evidence does not substantiate your statements.

(3) *Consideration of other evidence.* Since symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. The information that you, your treating or examining physician or psychologist, or other persons provide about your pain or other symptoms (e.g., what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions which you, your treating or examining physician or psychologist, or other persons report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph

(c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your treating, examining or consulting physician or psychologist, and observations by our employees and other persons. If you are a child, we will also consider all of the evidence presented, including evidence submitted by your treating, examining or consulting physician or psychologist, information from educational agencies and personnel, statements from parents and other relatives, and evidence submitted by social welfare agencies, therapists, and other practitioners. Section 416.927 explains in detail how we consider and weigh treating source and other medical opinions about the nature and severity of your impairment(s) and any related symptoms, such as pain. Factors relevant to your symptoms, such as pain, which we will consider include:

- (i) Your daily activities;
- (ii) The location, duration, frequency, and intensity of your pain or other symptoms;
- (iii) Precipitating and aggravating factors;
- (iv) The type, dosage, effectiveness, and side effects of any medication you take or have taken to alleviate your pain or other symptoms;
- (v) Treatment, other than medication, you receive or have received for relief of your pain or other symptoms;
- (vi) Any measures you use or have used to relieve your pain or other symptoms (e.g., lying flat on your back, standing for 15 to 20 minutes every hour, sleeping on a board, etc.); and
- (vii) Other factors concerning your functional limitations and restrictions due to pain or other symptoms.

(4) *How we determine the extent to which symptoms, such as pain, affect your capacity to perform basic work activities (or to function in an age-appropriate manner).* In determining the extent to which your symptoms, such as pain, affect your capacity to perform basic work activities (or if you are a child, to function independently, appropriately, and effectively in an age-

appropriate manner), we consider all of the available evidence described in paragraphs (c)(1) through (c)(3) of this section. We will consider your statements about the intensity, persistence, and limiting effects of your symptoms, and we will evaluate your statements in relation to the objective medical evidence and other evidence, in reaching a conclusion as to whether you are disabled. We will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between your statements and the rest of the evidence, including your medical history, the medical signs and laboratory findings, and statements by your treating or examining physician or psychologist, or other persons about how your symptoms affect you. Your symptoms, including pain, will be determined to diminish your capacity for basic work activities (or if you are a child, age-appropriate activities) to the extent that your alleged functional limitations and restrictions due to symptoms, such as pain, can reasonably be accepted as consistent with the objective medical evidence and other evidence.

(d) *Consideration of symptoms in the disability determination process.* We follow a set order of steps to determine whether you are disabled. If you are not doing substantial gainful activity, we consider your symptoms, such as pain, to evaluate whether you have a severe physical or mental impairment(s), and at each of the remaining steps in the process. Sections 416.920 and 416.920a (for adults) and 416.924 (for children) explain this process in detail. We also consider your symptoms, such as pain, at the appropriate steps in our review when we consider whether your disability continues. The procedure we follow in reviewing whether your disability continues is explained in §416.994 (for adults) and §416.994a (for children).

(1) *Need to establish a severe medically determinable impairment(s).* Your symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, are considered in making a determination as to whether your impairment or combination of impairment(s) is severe. (See §416.920(c) for adults and §416.924(d) for children.)

(2) *Decision whether the Listing of Impairments is met.* Some listed impairment(s) include symptoms, such as pain, as criteria. Section 416.925(f) explains how we consider your symptoms when your symptoms are included as criteria for a listed impairment.

(3) *Decision whether the Listing of Impairments is equaled.* If your impairment is not the same as a listed impairment, we must determine whether your impairment(s) is medically equivalent to a listed impairment. Sections 416.926 and 416.926a explain how we make this determination. Under §§416.926(b) and 416.926a(b) (1) and (2), we will consider equivalence based on medical evidence only. In considering whether your symptoms, signs, and laboratory findings are medically equal to the symptoms, signs, and laboratory findings of a listed impairment, we will look to see whether your symptoms, signs, and laboratory findings are at least equal in severity to the listed criteria. However, we will not substitute your allegations of pain or other symptoms for a missing or deficient sign or laboratory finding to raise the severity of your impairment(s) to that of a listed impairment. (If you are a child and we cannot find equivalence based on medical evidence only, we will consider pain and other symptoms under §416.926a(b)(3) in determining whether you have an impairment(s) that results in overall functional limitations that are the same as the disabling functional consequences of a listed impairment.) Regardless of whether you are an adult or a child, if the symptoms, signs, and laboratory findings of your impairment(s) are equivalent in severity to those of a listed impairment, we will find you disabled. (If you are a child and your impairment(s) is equivalent in severity to a listed impairment under the rules in §416.926a(b)(3), we also will find you disabled.) If they are not, we will consider the impact of your symptoms on your residual functional capacity if you are an adult or, if you are a child, on your ability to function in an age-appropriate manner. (See paragraph (d)(4) of this section.)

(4) *Impact of symptoms (including pain) on residual functional capacity or individualized functional assessment.* If you

have a medically determinable severe physical or mental impairment(s), but your impairment(s) does not meet or equal an impairment listed in Appendix 1 of subpart P of part 404 of this chapter, we will consider the impact of your impairment(s) and any related symptoms, including pain, on your residual functional capacity, or if you are a child, on your ability to function independently, appropriately, and effectively in an age-appropriate manner. (See §§416.945 and 416.924a through 416.924d.)

[56 FR 57944, Nov. 14, 1991]

§416.930 Need to follow prescribed treatment.

(a) *What treatment you must follow.*

In order to get benefits, you must follow treatment prescribed by your physician if this treatment can restore your ability to work.

(b) *When you do not follow prescribed treatment.* If you do not follow the prescribed treatment without a good reason, we will not find you disabled or blind or, if you are already receiving benefits, we will stop paying you benefits.

(c) *Acceptable reasons for failure to follow prescribed treatment.* We will consider your physical, mental, educational, and linguistic limitations (including any lack of facility with the English language) when determining if you have an acceptable reason for failure to follow prescribed treatment. The following are examples of a good reason for not following treatment:

(1) The specific medical treatment is contrary to the established teaching and tenets of your religion.

(2) The prescribed treatment would be cataract surgery for one eye when there is an impairment of the other eye resulting in a severe loss of vision and is not subject to improvement through treatment.

(3) Surgery was previously performed with unsuccessful results and the same surgery is again being recommended for the same impairment.

(4) The treatment because of its enormity (e.g. open heart surgery), unusual nature (e.g., organ transplant), or other reason is very risky for you; or

(5) The treatment involves amputation of an extremity, or a major part of an extremity.

[45 FR 55621, Aug. 20, 1980, as amended at 59 FR 1636, Jan. 12, 1994]

PRESUMPTIVE DISABILITY AND BLINDNESS

§416.931 The meaning of presumptive disability or presumptive blindness.

If you are applying for supplemental security income benefits on the basis of disability or blindness, we may pay you benefits before we make a formal finding of whether or not you are disabled or blind. In order to receive these payments, we must find that you are presumptively disabled or presumptively blind. You must also meet all other eligibility requirements for supplemental security income benefits. We may make these payments to you for a period not longer than 6 months. These payments will not be considered overpayments if we later find that you are not disabled or blind.

[45 FR 55621, Aug. 20, 1980, as amended at 57 FR 53853, Nov. 13, 1992]

§416.932 When presumptive payments begin and end.

We may make payments to you on the basis of presumptive disability or presumptive blindness before we make a formal determination about your disability or blindness. The payments can not be made for more than 6 months. They start for a period of not more than 6 months beginning in the month we make the presumptive disability or presumptive blindness finding. The payments end the earliest of—

(a) The month in which we make a formal finding on whether or not you are disabled or blind;

(b) The month for which we make the sixth monthly payment based on presumptive disability or presumptive blindness to you; or

(c) The month in which you no longer meet one of the other eligibility requirements (e.g., your income exceeds the limits).

[45 FR 55621, Aug. 20, 1980, as amended at 57 FR 53853, Nov. 13, 1992]

§416.933 How we make a finding of presumptive disability or presumptive blindness.

We may make a finding of presumptive disability or presumptive blindness if the evidence available at the time we make the presumptive disability or presumptive blindness finding reflects a high degree of probability that you are disabled or blind. In the case of readily observable impairments (e.g., amputation of extremities, total blindness), we will find that you are disabled or blind for purposes of this section without medical or other evidence. For other impairments, a finding of disability or blindness must be based on medical evidence or other information that, though not sufficient for a formal determination of disability or blindness, is sufficient for us to find that there is a high degree of probability that you are disabled or blind. For example, for claims involving the human immunodeficiency virus (HIV), the Social Security Field Office may make a finding of presumptive disability if your medical source provides us with information that confirms that your disease manifestations meet the severity of listing-level criteria for HIV. Of course, regardless of the specific HIV manifestations, the State agency may make a finding of presumptive disability if the medical evidence or other information reflects a high degree of probability that you are disabled.

[58 FR 36063, July 2, 1993]

§416.934 Impairments which may warrant a finding of presumptive disability or presumptive blindness.

We may make findings of presumptive disability and presumptive blindness in specific impairment categories without obtaining any medical evidence. These specific impairment categories are—

- (a) Amputation of two limbs;
- (b) Amputation of a leg at the hip;
- (c) Allegation of total deafness;
- (d) Allegation of total blindness;
- (e) Allegation of bed confinement or immobility without a wheelchair, walker, or crutches, due to a long-standing condition, excluding recent accident and recent surgery;
- (f) Allegation of a stroke (cerebral vascular accident) more than 3 months

in the past and continued marked difficulty in walking or using a hand or arm;

(g) Allegation of cerebral palsy, muscular dystrophy or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking, or coordination of the hands or arms.

(h) Allegation of diabetes with amputation of a foot;

(i) Allegation of Down's syndrome (Mongolism); and

(j) Allegation of severe mental deficiency made by another individual filing on behalf of a claimant who is at least 7 years of age. For example, a mother filing for benefits for her child states that the child attends (or attended) a special school, or special classes in school, because of mental deficiency or is unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities.

[45 FR 55621, Aug. 20, 1980, as amended at 50 FR 5574, Feb. 11, 1985; 53 FR 3741, Feb. 9, 1988; 56 FR 65684, Dec. 18, 1991]

DRUG ADDICTION AND ALCOHOLISM

§416.935 How we will determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) *General.* If we find that you are disabled and have medical evidence of your drug addiction or alcoholism, we must determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability, unless we find that you are eligible for benefits because of your age or blindness.

(b) *Process we will follow when we have medical evidence of your drug addiction or alcoholism.* (1) The key factor we will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether we would still find you disabled if you stopped using drugs or alcohol.

(2) In making this determination, we will evaluate which of your current physical and mental limitations, upon which we based our current disability determination, would remain if you stopped using drugs or alcohol and

then determine whether any or all of your remaining limitations would be disabling.

(i) If we determine that your remaining limitations would not be disabling, we will find that your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(ii) If we determine that your remaining limitations are disabling, you are disabled independent of your drug addiction or alcoholism and we will find that your drug addiction or alcoholism is not a contributing factor material to the determination of disability.

[60 FR 8151, Feb. 10, 1995]

§416.936 Treatment required for individuals whose drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) If we determine that you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability, you must avail yourself of appropriate treatment for your drug addiction or alcoholism at an institution or facility approved by us when this treatment is available and make progress in your treatment. Generally, you are not expected to pay for this treatment. You will not be paid benefits for any month after the month we have notified you in writing that—

(1) You did not comply with the terms, conditions and requirements of the treatment which has been made available to you; or

(2) You did not avail yourself of the treatment after you had been notified that it is available to you.

(b) If your benefits are suspended for failure to comply with treatment requirements, your benefits can be reinstated in accordance with the rules in §416.1326.

[60 FR 8151, Feb. 10, 1995]

§416.937 What we mean by appropriate treatment.

By appropriate treatment, we mean treatment for drug addiction or alcoholism that serves the needs of the individual in the least restrictive setting possible consistent with your treatment plan. These settings range from

outpatient counseling services through a variety of residential treatment settings including acute detoxification, short-term intensive residential treatment, long-term therapeutic residential treatment, and long-term recovery houses. Appropriate treatment is determined with the involvement of a State licensed or certified addiction professional on the basis of a detailed assessment of the individual's presenting symptomatology, psychosocial profile, and other relevant factors. This assessment may lead to a determination that more than one treatment modality is appropriate for the individual. The treatment will be provided or overseen by an approved institution or facility. This treatment may include (but is not limited to)—

- (a) Medical examination and medical management;
- (b) Detoxification;
- (c) Medication management to include substitution therapy (e.g., methadone);
- (d) Psychiatric, psychological, psychosocial, vocational, or other substance abuse counseling in a residential or outpatient treatment setting; or
- (e) Relapse prevention.

[60 FR 8151, Feb. 10, 1995]

§416.938 What we mean by approved institutions or facilities.

Institutions or facilities that we may approve include—

- (a) An institution or facility that furnishes medically recognized treatment for drug addiction or alcoholism in conformity with applicable Federal or State laws and regulations;
- (b) An institution or facility used by or licensed by an appropriate State agency which is authorized to refer persons for treatment of drug addiction or alcoholism;
- (c) State licensed or certified care providers;
- (d) Programs accredited by the Commission on Accreditation for Rehabilitation Facilities (CARF) and/or the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) for the treatment of drug addiction or alcoholism;
- (e) Medicare or Medicaid certified care providers; or

(f) Nationally recognized self-help drug addiction or alcoholism recovery programs (e.g., Alcoholics Anonymous or Narcotics Anonymous) when participation in these programs is specifically prescribed by a treatment professional at an institution or facility described in paragraphs (a) through (e) of this section as part of an individual's treatment plan.

[60 FR 8151, Feb. 10, 1995]

§416.939 How we consider whether treatment is available.

Our determination about whether treatment is available to you for your drug addiction or your alcoholism will depend upon—

- (a) The capacity of an approved institution or facility to admit you for appropriate treatment;
- (b) The location of the approved institution or facility, or the place where treatment, services or resources could be provided to you;
- (c) The availability and cost of transportation for you to the place of treatment;
- (d) Your general health, including your ability to travel and capacity to understand and follow the prescribed treatment;
- (e) Your particular condition and circumstances; and
- (f) The treatment that is prescribed for your drug addiction or alcoholism.

[60 FR 8151, Feb. 10, 1995]

§416.940 Evaluating compliance with the treatment requirements.

(a) *General.* Generally, we will consider information from the treatment institution or facility to evaluate your compliance with your treatment plan. The treatment institution or facility will—

- (1) Monitor your attendance at and participation in treatment sessions;
- (2) Provide reports of the results of any clinical testing (such as, hematological or urinalysis studies for individuals with drug addiction and hematological studies and breath analysis for individuals with alcoholism) when such tests are likely to yield important information;
- (3) Provide observational reports from the treatment professionals

Social Security Administration

familiar with your individual case (subject to verification and Federal confidentiality requirements); or

(4) Provide their assessment or views on your noncompliance with treatment requirements.

(b) *Measuring progress.* Generally, we will consider information from the treatment institution or facility to evaluate your progress in completing your treatment plan. Examples of milestones for measuring your progress with the treatment which has been prescribed for your drug addiction or alcoholism may include (but are not limited to)—

- (1) Abstinence from drug or alcohol use (initial progress may include significant reduction in use);
- (2) Consistent attendance at and participation in treatment sessions;
- (3) Improved social functioning and levels of gainful activity;
- (4) Participation in vocational rehabilitation activities; or
- (5) Avoidance of criminal activity.

[60 FR 8151, Feb. 10, 1995]

§416.941 Establishment and use of referral and monitoring agencies.

We will contract with one or more agencies in each of the States and the District of Columbia to provide services to individuals whose disabilities are based on a determination that drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in §416.935) and to submit information to us which we will use to make decisions about these individuals' benefits. These agencies will be known as referral and monitoring agencies. Their duties and responsibilities include (but are not limited to)—

- (a) Identifying appropriate treatment placements for individuals we refer to them;
- (b) Referring these individuals for treatment;
- (c) Monitoring the compliance and progress with the appropriate treatment of these individuals; and
- (d) Promptly reporting to us any individual's failure to comply with treatment requirements as well as failure to

achieve progress through the treatment.

[60 FR 8152, Feb. 10, 1995]

RESIDUAL FUNCTIONAL CAPACITY

§416.945 Your residual functional capacity.

(a) *General.* Your impairment(s), and any related symptoms, such as pain, may cause physical and mental limitations that affect what you can do in a work setting. Your residual functional capacity is what you can still do despite your limitations. If you have more than one impairment, we will consider all of your impairment(s) of which we are aware. We will consider your ability to meet certain demands of jobs, such as physical demands, mental demands, sensory requirements, and other functions, as described in paragraphs (b), (c), and (d) of this section. Residual functional capacity is an assessment based upon all of the relevant evidence. It may include descriptions (even your own) of limitations that go beyond the symptoms, such as pain, that are important in the diagnosis and treatment of your medical condition. Observations by your treating or examining physicians or psychologists, your family, neighbors, friends, or other persons, of your limitations, in addition to those observations usually made during formal medical examinations, may also be used. These descriptions and observations, when used, must be considered along with your medical records to enable us to decide to what extent your impairment(s) keeps you from performing particular work activities. This assessment of your remaining capacity for work is not a decision on whether you are disabled, but is used as the basis for determining the particular types of work you may be able to do despite your impairment(s). Then, using the guidelines in §§416.960 through 416.969a, your vocational background is considered along with your residual functional capacity in arriving at a disability determination or decision. In deciding whether your disability continues or ends, the residual functional capacity assessment may also be used to determine whether any medical improvement you have

experienced is related to your ability to work as discussed in §416.994.

(b) *Physical abilities.* When we assess your physical abilities, we first assess the nature and extent of your physical limitations and then determine your residual functional capacity for work activity on a regular and continuing basis. A limited ability to perform certain physical demands of work activity, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping or crouching), may reduce your ability to do past work and other work.

(c) *Mental abilities.* When we assess your mental abilities, we first assess the nature and extent of your mental limitations and restrictions and then determine your residual functional capacity for work activity on a regular and continuing basis. A limited ability to carry out certain mental activities, such as limitations in understanding, remembering, and carrying out instructions, and in responding appropriately to supervision, coworkers, and work pressures in a work setting, may reduce your ability to do past work and other work.

(d) *Other abilities affected by impairment(s).* Some medically determinable impairment(s), such as skin impairment(s), epilepsy, impairment(s) of vision, hearing or other senses, and impairment(s) which impose environmental restrictions, may cause limitations and restrictions which affect other work-related abilities. If you have this type of impairment(s), we consider any resulting limitations and restrictions which may reduce your ability to do past work and other work in deciding your residual functional capacity.

(e) *Total limiting effects.* When you have a severe impairment(s), but your symptoms, signs, and laboratory findings do not meet or equal those of a listed impairment in appendix 1 of subpart P of part 404 of this chapter, we will consider the limiting effects of all your impairment(s), even those that are not severe, in determining your residual functional capacity. Pain or other symptoms may cause a limitation of function beyond that which can

be determined on the basis of the anatomical, physiological or psychological abnormalities considered alone; e.g., someone with a low back disorder may be fully capable of the physical demands consistent with those of sustained medium work activity, but another person with the same disorder, because of pain, may not be capable of more than the physical demands consistent with those of light work activity on a sustained basis. In assessing the total limiting effects of your impairment(s) and any related symptoms, we will consider all of the medical and nonmedical evidence, including the information described in §416.929(c).

[56 FR 57947, Nov. 14, 1991]

§416.946 Responsibility for assessing and determining residual functional capacity.

The State agency staff medical or psychological consultants or other medical or psychological consultants designated by the Secretary are responsible for ensuring that the State agency makes a decision about your residual functional capacity. In cases where the State agency makes the disability determination, a State agency staff medical or psychological consultant must assess residual functional capacity where it is required. This assessment is based on all of the evidence we have, including any statements regarding what you can still do that have been provided by treating or examining physicians, consultative physicians, or any other medical or psychological consultant designated by the Secretary. See §416.945. For cases in the disability hearing process, the responsibility for deciding your residual functional capacity rests with either the disability hearing officer or, if the disability hearing officer's reconsidered determination is changed under §416.918, with the Director of the Office of Disability Hearings or his or her delegate. For cases at the Administrative Law Judge hearing or Appeals Council level, the responsibility for deciding your residual functional capacity rests with the Administrative Law Judge or Appeals Council.

[56 FR 36970, Aug. 1, 1991]

VOCATIONAL CONSIDERATIONS

§416.960 When your vocational background will be considered.

(a) *General.* If you are age 18 or older and applying for benefits based on disability and we cannot decide whether you are disabled on medical evidence alone, we will consider your residual functional capacity together with your vocational background.

(b) *Past relevant work.* We will first compare your residual functional capacity with the physical and mental demands of the kind of work you have done in the past. If you still have the residual functional capacity to do your past relevant work, we will find that you can still do your past work, and we will determine that you are not disabled, without considering your vocational factors of age, education, and work experience.

(c) *Other work.* If we find that you can no longer do the kind of work you have done in the past, we will then consider your residual functional capacity together with your vocational factors of age, education, and work experience to determine whether you can do other work. By other work we mean jobs that exist in significant numbers in the national economy.

[55 FR 11011, Mar. 26, 1990]

§416.961 Your ability to do work depends upon your residual functional capacity.

If you can do your previous work (your usual work or other applicable past work), we will determine that you are not disabled. However, if your residual functional capacity is not enough to enable you to do any of your previous work, we must still decide if you can do any other work. To do this, we consider your residual functional capacity, and your age, education, and work experience. Any work (jobs) that you can do must exist in significant numbers in the national economy (either in the region where you live or in several regions of the country). Sections 416.963 through 416.965 explain how we evaluate your age, education, and work experience when we are deciding whether or not you are able to do other work.

§416.962 If you have done only arduous unskilled physical labor.

If you have only a marginal education and work experience of 35 years or more during which you did arduous unskilled physical labor, and you are not working and are no longer able to do this kind of work because of a severe impairment(s), we will consider you unable to do lighter work, and therefore, disabled. However, if you are working or have worked despite your impairment(s) (except where the work is sporadic or is not medically advisable), we will review all the facts in your case, and we may find that you are not disabled. In addition, we will consider that you are not disabled if the evidence shows that you have training or past work experience which enables you to do substantial gainful activity in another occupation with your impairment, either on a full-time or a reasonably regular part-time basis.

Example: B is a 60-year-old miner with a fourth grade education who has a life-long history of arduous physical labor. B says that he is disabled because of arthritis of the spine, hips, and knees, and other impairments. Medical evidence shows a combination of impairments and establishes that these impairments prevent B from performing his usual work or any other type of arduous physical labor. His vocational background does not show that he has skills or capabilities needed to do lighter work which would be readily transferable to another work setting. Under these circumstances, we will find that B is disabled.

§416.963 Your age as a vocational factor.

(a) *General.* Age refers to how old you are (your chronological age) and the extent to which your age affects your ability to adapt to a new work situation and to do work in competition with others. However, we do not determine disability on your age alone. We must also consider your residual functional capacity, education, and work experience. If you are unemployed because of your age and you can still do a significant number of jobs which exist in the national economy, we will find that you are not disabled. We explain age as a vocational factor in appendix 2 of subpart P of part 404 of this chapter. However, we will not apply

these age categories mechanically in a borderline situation.

(b) *Younger person.* If you are under age 50, we generally do not consider that your age will seriously affect your ability to adapt to a new work situation. In some circumstances, however, we consider age 45 a handicap in adapting to a new work setting (see Rule 201.17 in appendix 2 of subpart P of part 404 of this chapter).

(c) *Person approaching advanced age.* If you are closely approaching advanced age (50-54), we will consider that your age, along with a severe impairment and limited work experience, may seriously affect your ability to adjust to a significant number of jobs in the national economy.

(d) *Person of advanced age.* We consider that advanced age (55 or over) is the point where age significantly affects a person's ability to do substantial gainful activity. If you are severely impaired and of advanced age and you cannot do medium work (see §416.967(c)), you may not be able to work unless you have skills that can be used in (transferred to) less demanding jobs which exist in significant numbers in the national economy. If you are close to retirement age (60-64) and have a severe impairment, we will not consider you able to adjust to sedentary or light work unless you have skills which are highly marketable.

(e) *Information about your age.* We will usually not ask you to prove your age. However, if we need to know your exact age to determine whether you get disability benefits, we will ask you for evidence of your age.

§416.964 Your education as a vocational factor.

(a) *General.* Education is primarily used to mean formal schooling or other training which contributes to your ability to meet vocational requirements, for example, reasoning ability, communication skills, and arithmetical ability. However, if you do not have formal schooling, this does not necessarily mean that you are uneducated or lack these abilities. Past work experience and the kinds of responsibilities you had when you were working may show that you have intellectual abilities, although you may

have little formal education. Your daily activities, hobbies, or the results of testing may also show that you have significant intellectual ability that can be used to work.

(b) *How we evaluate your education.* The importance of your educational background may depend upon how much time has passed between the completion of your formal education and the beginning of your physical or mental impairment(s) and by what you have done with your education in a work or other setting. Formal education that you completed many years before your impairment began, or unused skills and knowledge that were a part of your formal education, may no longer be useful or meaningful in terms of your ability to work. Therefore, the numerical grade level that you completed in school may not represent your actual educational abilities. These may be higher or lower. However, if there is no other evidence to contradict it, we will use your numerical grade level to determine your educational abilities. The term *education* also includes how well you are able to communicate in English since this ability is often acquired or improved by education. In evaluating your educational level, we use the following categories:

(1) *Illiteracy.* Illiteracy means the inability to read or write. We consider someone illiterate if the person cannot read or write a simple message such as instructions or inventory lists even though the person can sign his or her name. Generally, an illiterate person has had little or no formal schooling.

(2) *Marginal education.* Marginal education means ability in reasoning, arithmetic, and language skills which are needed to do simple, unskilled types of jobs. We generally consider that formal schooling at a 6th grade level or less is a marginal education.

(3) *Limited education.* Limited education means ability in reasoning, arithmetic, and language skills, but not enough to allow a person with these educational qualifications to do most of the more complex job duties needed in semi-skilled or skilled jobs. We generally consider that a 7th grade through the 11th grade level of formal education is a limited education.

(4) *High school education and above.* High school education and above means abilities in reasoning, arithmetic, and language skills acquired through formal schooling at a 12th grade level or above. We generally consider that someone with these educational abilities can do semi-skilled through skilled work.

(5) *Inability to communicate in English.* Since the ability to speak, read and understand English is generally learned or increased at school, we may consider this an educational factor. Because English is the dominant language of the country, it may be difficult for someone who doesn't speak and understand English to do a job, regardless of the amount of education the person may have in another language. Therefore, we consider a person's ability to communicate in English when we evaluate what work, if any, he or she can do. It generally doesn't matter what other language a person may be fluent in.

(6) *Information about your education.* We will ask you how long you attended school and whether you are able to speak, understand, read and write in English and do at least simple calculations in arithmetic. We will also consider other information about how much formal or informal education you may have had through your previous work, community projects, hobbies, and any other activities which might help you to work.

§416.965 Your work experience as a vocational factor.

(a) *General.* Work experience means skills and abilities you have acquired through work you have done which show the type of work you may be expected to do. Work you have already been able to do shows the kind of work that you may be expected to do. We consider that your work experience applies when it was done within the last 15 years, lasted long enough for you to learn to do it, and was substantial gainful activity. We do not usually consider that work you did 15 years or more before the time we are deciding whether you are disabled applies. A gradual change occurs in most jobs so that after 15 years it is no longer realistic to expect that skills and abilities

acquired in a job done then continue to apply. The 15-year guide is intended to insure that remote work experience is not currently applied. If you have no work experience or worked only off-and-on or for brief periods of time during the 15-year period, we generally consider that these do not apply. If you have acquired skills through your past work, we consider you to have these work skills unless you cannot use them in other skilled or semi-skilled work that you can now do. If you cannot use your skills in other skilled or semi-skilled work, we will consider your work background the same as unskilled. However, even if you have no work experience, we may consider that you are able to do unskilled work because it requires little or no judgment and can be learned in a short period of time.

(b) *Information about your work.* Under certain circumstances, we will ask you about the work you have done in the past. If you cannot give us all of the information we need, we will try, with your permission, to get it from your employer or other person who knows about your work, such as a member of your family or a co-worker. When we need to consider your work experience to decide whether you are able to do work that is different from what you have done in the past, we will ask you to tell us about all of the jobs you have had in the last 15 years. You must tell us the dates you worked, all of the duties you did, and any tools, machinery, and equipment you used. We will need to know about the amount of walking, standing, sitting, lifting and carrying you did during the work day, as well as any other physical or mental duties of your job. If all of your work in the past 15 years has been arduous and unskilled, and you have very little education, we will ask you to tell us about all of your work from the time you first began working. This information could help you to get disability benefits.

§416.966 Work which exists in the national economy.

(a) *General.* We consider that work exists in the national economy when it exists in significant numbers either in the region where you live or in several

other regions of the country. It does not matter whether—

(1) Work exists in the immediate area in which you live;

(2) A specific job vacancy exists for you; or

(3) You would be hired if you applied for work.

(b) *How we determine the existence of work.* Work exists in the national economy when there is a significant number of jobs (in one or more occupations) having requirements which you are able to meet with your physical or mental abilities and vocational qualifications. Isolated jobs that exist only in very limited numbers in relatively few locations outside of the region where you live are not considered *work which exists in the national economy*. We will not deny you disability benefits on the basis of the existence of these kinds of jobs. If work that you can do does not exist in the national economy, we will determine that you are disabled. However, if work that you can do does exist in the national economy, we will determine that you are not disabled.

(c) *Inability to obtain work.* We will determine that you are not disabled if your residual functional capacity and vocational abilities make it possible for you to do work which exists in the national economy, but you remain unemployed because of—

(1) Your inability to get work;

(2) Lack of work in your local area;

(3) The hiring practices of employers;

(4) Technological changes in the industry in which you have worked;

(5) Cyclical economic conditions;

(6) No job openings for you;

(7) You would not actually be hired to do work you could otherwise do, or;

(8) You do not wish to do a particular type of work.

(d) *Administrative notice of job data.* When we determine that unskilled, sedentary, light, and medium jobs exist in the national economy (in significant numbers either in the region where you live or in several regions of the country), we will take administrative notice of reliable job information available from various governmental and other publications. For example, we will take notice of—

(1) *Dictionary of Occupational Titles*, published by the Department of Labor;

(2) *County Business Patterns*, published by the Bureau of the Census;

(3) *Census Reports*, also published by the Bureau of the Census;

(4) *Occupational Analyses* prepared for the Social Security Administration by various State employment agencies; and

(5) *Occupational Outlook Handbook*, published by the Bureau of Labor Statistics.

(e) *Use of vocational experts and other specialists.* If the issue in determining whether you are disabled is whether your work skills can be used in other work and the specific occupations in which they can be used, or there is a similarly complex issue, we may use the services of a vocational expert or other specialist. We will decide whether to use a vocational expert or other specialist.

§416.967 Physical exertion requirements.

To determine the physical exertion requirements of work in the national economy, we classify jobs as *sedentary*, *light*, *medium*, *heavy*, and *very heavy*. These terms have the same meaning as they have in the *Dictionary of Occupational Titles*, published by the Department of Labor. In making disability determinations under this subpart, we use the following definitions:

(a) *Sedentary work.* Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

(b) *Light work.* Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To

be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

(c) *Medium work.* Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work.

(d) *Heavy work.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work.

(e) *Very heavy work.* Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, we determine that he or she can also do heavy, medium, light, and sedentary work.

§416.968 Skill requirements.

In order to evaluate your skills and to help determine the existence in the national economy of work you are able to do, occupations are classified as unskilled, semi-skilled, and skilled. In classifying these occupations, we use materials published by the Department of Labor. When we make disability determinations under this subpart, we use the following definitions:

(a) *Unskilled work.* Unskilled work is work which needs little or no judgment to do simple duties that can be learned on the job in a short period of time. The job may or may not require considerable strength. For example, we consider jobs unskilled if the primary work duties are handling, feeding and offbearing (that is, placing or removing materials from machines which are automatic or operated by others), or machine tending, and a person can usually learn to do the job in 30 days, and little specific vocational preparation and judgment are needed. A person

does not gain work skills by doing unskilled jobs.

(b) *Semi-skilled work.* Semi-skilled work is work which needs some skills but does not require doing the more complex work duties. Semi-skilled jobs may require alertness and close attention to watching machine processes; or inspecting, testing or otherwise looking for irregularities; or tending or guarding equipment, property, materials, or persons against loss, damage or injury; or other types of activities which are similarly less complex than skilled work, but more complex than unskilled work. A job may be classified as semi-skilled where coordination and dexterity are necessary, as when hands or feet must be moved quickly to do repetitive tasks.

(c) *Skilled work.* Skilled work requires qualifications in which a person uses judgment to determine the machine and manual operations to be performed in order to obtain the proper form, quality, or quantity of material to be produced. Skilled work may require laying out work, estimating quality, determining the suitability and needed quantities of materials, making precise measurements, reading blueprints or other specifications, or making necessary computations or mechanical adjustments to control or regulate the work. Other skilled jobs may require dealing with people, facts, or figures or abstract ideas at a high level of complexity.

(d) *Skills that can be used in other work (transferability).*—(1) *What we mean by transferable skills.* We consider you to have skills that can be used in other jobs, when the skilled or semi-skilled work activities you did in past work can be used to meet the requirements of skilled or semi-skilled work activities of other jobs or kinds of work. This depends largely on the similarity of occupationally significant work activities among different jobs.

(2) *How we determine skills that can be transferred to other jobs.* Transferability is most probable and meaningful among jobs in which—

(i) The same or a lesser degree of skill is required;

(ii) The same or similar tools and machines are used; and

(iii) The same or similar raw materials, products, processes, or services are involved.

(3) *Degrees of transferability.* There are degrees of transferability of skills ranging from very close similarities to remote and incidental similarities among jobs. A complete similarity of all three factors is not necessary for transferability. However, when skills are so specialized or have been acquired in such an isolated vocational setting (like many jobs in mining, agriculture, or fishing) that they are not readily usable in other industries, jobs, and work settings, we consider that they are not transferable.

§416.969 Listing of Medical-Vocational Guidelines in Appendix 2 of Subpart P of Part 404 of this chapter.

The *Dictionary of Occupational Titles* includes information about jobs (classified by their exertional and skill requirements) that exist in the national economy. Appendix 2 provides rules using this data reflecting major functional and vocational patterns. We apply these rules in cases where a person is not doing substantial gainful activity and is prevented by a severe medically determinable impairment from doing vocationally relevant past work. The rules in appendix 2 do not cover all possible variations of factors. Also, as we explain in §200.00 of appendix 2, we do not apply these rules if one of the findings of fact about the person's vocational factors and residual functional capacity is not the same as the corresponding criterion of a rule. In these instances, we give full consideration to all relevant facts in accordance with the definitions and discussions under vocational considerations. However, if the findings of fact made about all factors are the same as the rule, we use that rule to decide whether a person is disabled.

§416.969a Exertional and nonexertional limitations.

(a) *General.* Your impairment(s) and related symptoms, such as pain, may cause limitations of function or restrictions which limit your ability to meet certain demands of jobs. These limitations may be exertional, nonexertional, or a combination of

both. Limitations are classified as exertional if they affect your ability to meet the strength demands of jobs. The classification of a limitation as exertional is related to the United States Department of Labor's classification of jobs by various exertional levels (sedentary, light, medium, heavy, and very heavy) in terms of the strength demands for sitting, standing, walking, lifting, carrying, pushing, and pulling. Sections 416.967 and 416.969 explain how we use the classification of jobs by exertional levels (strength demands) which is contained in the *Dictionary of Occupational Titles* published by the Department of Labor, to determine the exertional requirements of work which exists in the national economy. Limitations or restrictions which affect your ability to meet the demands of jobs other than the strength demands, that is, demands other than sitting, standing, walking, lifting, carrying, pushing or pulling, are considered nonexertional. Sections 416.920(f) and 416.994(b)(5)(viii) explain that if you can no longer do your past relevant work because of a severe medically determinable impairment(s), we must determine whether your impairment(s), when considered along with your age, education, and work experience, prevents you from doing any other work which exists in the national economy in order to decide whether you are disabled (§416.920(f)) or continue to be disabled (§416.994(b)(5)(viii)). Paragraphs (b), (c), and (d) of this section explain how we apply the medical-vocational guidelines in appendix 2 of subpart P of part 404 of this chapter in making this determination, depending on whether the limitations or restrictions imposed by your impairment(s) and related symptoms, such as pain, are exertional, nonexertional, or a combination of both.

(b) *Exertional limitations.* When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the strength demands of jobs (sitting, standing, walking, lifting, carrying, pushing, and pulling), we consider that you have only exertional limitations. When your impairment(s) and related symptoms only impose

exertional limitations and your specific vocational profile is listed in a rule contained in Appendix 2, we will directly apply that rule to decide whether you are disabled.

(c) *Nonexertional limitations.* (1) When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the demands of jobs other than the strength demands, we consider that you have only nonexertional limitations or restrictions. Some examples of nonexertional limitations or restrictions include the following:

(i) You have difficulty functioning because you are nervous, anxious, or depressed;

(ii) You have difficulty maintaining attention or concentrating;

(iii) You have difficulty understanding or remembering detailed instructions;

(iv) You have difficulty in seeing or hearing;

(v) You have difficulty tolerating some physical feature(s) of certain work settings, e.g., you cannot tolerate dust or fumes; or

(vi) You have difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching.

(2) If your impairment(s) and related symptoms, such as pain, only affect your ability to perform the nonexertional aspects of work-related activities, the rules in appendix 2 do not direct factual conclusions of disabled or not disabled. The determination as to whether disability exists will be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in appendix 2.

(d) *Combined exertional and nonexertional limitations.* When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect your ability to meet both the strength and demands of jobs other than the strength demands, we consider that you have a combination of exertional and nonexertional limitations or restrictions. If your impairment(s) and related symptoms, such as pain, affect your

ability to meet both the strength and demands of jobs other than the strength demands, we will not directly apply the rules in appendix 2 unless there is a rule that directs a conclusion that you are disabled based upon your strength limitations; otherwise the rules provide a framework to guide our decision.

[56 FR 57947, Nov. 14, 1991]

SUBSTANTIAL GAINFUL ACTIVITY

§416.971 General.

The work that you have done during any period in which you believe you are disabled may show that you are able to do work at the substantial gainful activity level. If you are able to engage in substantial gainful activity, we will find that you are not disabled. (We explain the rules for persons who are statutorily blind in §416.984.) Even if the work you have done was not substantial gainful activity, it may show that you are able to do more work than you actually did. We will consider all of the medical and vocational evidence in your file to decide whether or not you have the ability to engage in substantial gainful activity.

§416.972 What we mean by substantial gainful activity.

Substantial gainful activity is work activity that is both substantial and gainful:

(a) *Substantial work activity.* Substantial work activity is work activity that involves doing significant physical or mental activities. Your work may be substantial even if it is done on a part-time basis or if you do less, get paid less, or have less responsibility than when you worked before.

(b) *Gainful work activity.* Gainful work activity is work activity that you do for pay or profit. Work activity is gainful if it is the kind of work usually done for pay or profit, whether or not a profit is realized.

(c) *Some other activities.* Generally, we do not consider activities like taking care of yourself, household tasks, hobbies, therapy, school attendance, club activities, or social programs to be substantial gainful activity.

§416.973 General information about work activity.

(a) *The nature of your work.* If your duties require use of your experience, skills, supervision and responsibilities, or contribute substantially to the operation of a business, this tends to show that you have the ability to work at the substantial gainful activity level.

(b) *How well you perform.* We consider how well you do your work when we determine whether or not you are doing substantial gainful activity. If you do your work satisfactorily, this may show that you are working at the substantial gainful activity level. If you are unable, because of your impairments, to do ordinary or simple tasks satisfactorily without more supervision or assistance than is usually given other people doing similar work, this may show that you are not working at the substantial gainful activity level. If you are doing work that involves minimal duties that make little or no demands on you and that are of little or no use to your employer, or to the operation of a business if you are self-employed, this does not show that you are working at the substantial gainful activity level.

(c) *If your work is done under special conditions.* Even though the work you are doing takes into account your impairment, such as work done in a sheltered workshop or as a patient in a hospital, it may still show that you have the necessary skills and ability to work at the substantial gainful activity level.

(d) *If you are self-employed.* Supervisory, managerial, advisory or other significant personal services that you perform as a self-employed individual may show that you are able to do substantial gainful activity.

(e) *Time spent in work.* While the time you spend in work is important, we will not decide whether or not you are doing substantial gainful activity only on that basis. We will still evaluate the work to decide whether it is substantial and gainful regardless of whether you spend more time or less time at the job than workers who are not impaired and who are doing similar work as a regular means of their livelihood.

(f) *Possible effect on income and resource levels.* Your earnings, including

earnings from work done during a trial work period, will be considered under the income and resource provisions in subparts K and L of this part to determine whether or not your earnings cause you to exceed the limitations on income or resources under the Supplemental Security Income Program.

§416.974 Evaluation guides if you are an employee.

(a) *General.* We use several guides to decide whether the work you have done shows that you are able to do substantial gainful activity.

(1) *Your earnings may show you have done substantial gainful activity.* The amount of your earnings from work you have done may show that you engaged in substantial gainful activity. Generally, if you worked for substantial earnings, this will show that you are able to do substantial gainful activity. On the other hand, the fact that your earnings are not substantial will not necessarily show that you are not able to do substantial gainful activity. We will generally consider work that you are forced to stop after a short time because of your impairment as an unsuccessful work attempt and your earnings from that work will not show that you are able to do substantial gainful activity.

(2) *We consider only the amounts you earn.* We do not consider any income not directly related to your productivity when we decide whether you have done substantial gainful activity. If your earnings are being subsidized, the amount of the subsidy is not counted when we determine whether or not your work is substantial gainful activity. Thus, where work is done under special conditions, we only consider the part of your pay which you actually "earn". For example, where a handicapped person does simple tasks under close and continuous supervision, we would not determine that the person worked at the substantial gainful activity level only on the basis of the amount of pay. An employer may set a specific amount as a subsidy after figuring the reasonable value of the employee's services. If your work is subsidized and your employer does not set the amount of the subsidy or does not adequately explain how the subsidy

was figured, we will investigate to see how much your work is worth.

(3) *If you are working in a sheltered or special environment.* If you are working in a sheltered workshop, you may or may not be earning the amounts you are being paid. The fact that the sheltered workshop or similar facility is operating at a loss or is receiving some charitable contributions or governmental aid does not establish that you are not earning all you are being paid. Since persons in military service being treated for severe impairments usually continue to receive full pay, we evaluate work activity in a therapy program or while on limited duty by comparing it with similar work in the civilian work force or on the basis of reasonable worth of the work, rather than on the actual amount of the earnings.

(b) *Earnings guidelines.* (1) *General.* If you are an employee, we first consider the criteria in paragraph (a) of this section, and §416.976, and then the guides in paragraphs (b)(2), (3), (4), (5), and (6) of this section.

(2) *Earnings that will ordinarily show that you have engaged in substantial gainful activity.* We will consider that your earnings from your work activities as an employee show that you have engaged in substantial gainful activity if—

- (i) Your earnings averaged more than \$200 a month in calendar years prior to 1976;
- (ii) Your earnings averaged more than \$230 a month in calendar year 1976;
- (iii) Your earnings averaged more than \$240 a month in calendar year 1977;
- (iv) Your earnings averaged more than \$260 a month in calendar year 1978;
- (v) Your earnings averaged more than \$280 a month in calendar year 1979;
- (vi) Your earnings averaged more than \$300 a month in calendar years after 1979 and before 1990; or
- (vii) Your earnings averaged more than \$500 a month in calendar years after 1989.

(3) *Earnings that will ordinarily show that you have not engaged in substantial gainful activity.* We will generally consider that the earnings from your work

as an employee will show that you have not engaged in substantial gainful activity if—

- (i) Your earnings averaged less than \$130 a month in calendar years before 1976;
- (ii) Your earnings averaged less than \$150 a month in calendar year 1976;
- (iii) Your earnings averaged less than \$160 a month in calendar year 1977;
- (iv) Your earnings averaged less than \$170 a month in calendar year 1978;
- (v) Your earnings averaged less than \$180 a month in calendar year 1979;
- (vi) Your earnings averaged less than \$190 a month in calendar years after 1979 and before 1990; or
- (vii) Your earnings averaged less than \$300 a month in calendar years after 1989.

(4) *If you work in a sheltered workshop.* If you are working in a sheltered workshop or a comparable facility especially set up for severely impaired persons, your earnings and activities will ordinarily establish that you have not done substantial gainful activity if—

- (i) Your average earnings are not greater than \$200 a month in calendar years prior to 1976;
- (ii) Your average earnings are not greater than \$230 a month in calendar year 1976;
- (iii) Your average earnings are not greater than \$240 a month in calendar year 1977;
- (iv) Your average earnings are not greater than \$260 a month in calendar year 1978;
- (v) Your average earnings are not greater than \$280 a month in calendar year 1979;
- (vi) Your average earnings are not greater than \$300 a month in calendar years after 1979 and before 1990; or
- (vii) Your average earnings are not greater than \$500 a month in calendar years after 1989.

(5) *If there is evidence showing that you may have done substantial gainful activity.* If there is evidence showing that you may have done substantial gainful activity, we will apply the criteria in paragraph (b)(6) of this section regarding comparability and value of services.

(6) *Earnings that are not high or low enough to show whether you engaged in substantial gainful activity.* If your

earnings, on the average, are between the amounts shown in paragraphs (b)(2) and (3) of this section, we will generally consider other information in addition to your earnings, such as whether—

(i) Your work is comparable to that of unimpaired people in your community who are doing the same or similar occupations as their means of livelihood, taking into account the time, energy, skill, and responsibility involved in the work, or

(ii) Your work, although significantly less than that done by unimpaired people, is clearly worth the amounts shown in paragraph (b)(2) of this section, according to pay scales in your community.

[46 FR 4871, Jan. 19, 1981, as amended at 48 FR 21939, May 16, 1983; 49 FR 22274, May 29, 1984; 54 FR 53605, Dec. 29, 1989]

\$416.975 Evaluation guides if you are self-employed.

(a) *If you are a self employed person.* We will consider your activities and their value to your business to decide whether you have engaged in substantial gainful activity if you are self-employed. We will not consider your income alone since the amount of income you actually receive may depend upon a number of different factors like capital investment, profit sharing agreements, etc. We will generally consider work that you are forced to stop after a short time because of your impairment as an unsuccessful work attempt and your income from that work will not show that you are able to do substantial gainful activity. We will evaluate your work activity on the value to the business of your services regardless of whether you receive an immediate income for your services. We consider that you have engaged in substantial gainful activity if—

(1) Your work activity, in terms of factors such as hours, skills, energy output, efficiency, duties, and responsibilities, is comparable to that of unimpaired individuals in your community who are in the same or similar businesses as their means of livelihood;

(2) Your work activity, although not comparable to that of unimpaired individuals, is clearly worth the amount shown in \$416.974(b)(2) when considered

in terms of its value to the business, or when compared to the salary that an owner would pay to an employee to do the work you are doing; or

(3) You render services that are significant to the operation of the business and receive a substantial income from the business.

(b) *What we mean by significant services.* (1) If you are not a farm landlord and you operate a business entirely by yourself, any services that you render are significant to the business. If your business involves the services of more than one person, we will consider you to be rendering significant services if you contribute more than half the total time required for the management of the business, or you render management services for more than 45 hours a month regardless of the total management time required by the business.

(2) If you are a farm landlord, that is, you rent farm land to another, we will consider you to be rendering significant services if you materially participate in the production or the management of the production of the things raised on the rented farm. (See \$404.1082 of this chapter for an explanation of "material participation".) If you were given social security earnings credits because you materially participated in the activities of the farm and you continue these same activities, we will consider you to be rendering significant services.

(c) *What we mean by substantial income.* After your normal business expenses are deducted from your gross income to determine net income, we will deduct the reasonable value of any unpaid help, any soil bank payments that were included as farm income, and impairment-related work expenses described in \$416.976 that have not been deducted in determining your net earnings from self-employment. We will consider the resulting amount of income from the business to be substantial if—

(1) It averages more than the amounts described in \$416.974(b)(2); or

(2) It averages less than the amounts described in \$416.974(b)(2) but the livelihood which you get from the business is either comparable to what it was before you became severely impaired or

is comparable to that of unimpaired self-employed persons in your community who are in the same or similar business as their means of livelihood.

[46 FR 4872, Jan. 19, 1981, as amended at 48 FR 21940, May 16, 1983; 49 FR 22274, May 29, 1984]

\$416.976 Impairment-related work expenses.

(a) *General.* When we figure your earnings in deciding if you have done substantial gainful activity, and in determining your countable earned income (see \$416.1112(c)(5)), we will subtract the reasonable costs to you of certain items and services which, because of your impairment(s), you need and use to enable you to work. The costs are deductible even though you also need or use the items and services to carry out daily living functions unrelated to your work. Paragraph (b) of this section explains the conditions for deducting work expenses. Paragraph (c) of this section describes the expenses we will deduct. Paragraph (d) of this section explains when expenses may be deducted. Paragraph (e) of this section describes how expenses may be allocated. Paragraph (f) of this section explains the limitations on deducting expenses. Paragraph (g) of this section explains our verification procedures.

(b) *Conditions for deducting impairment-related work expenses.* We will deduct impairment-related work expenses if—

(1) You are otherwise disabled as defined in §§416.905 through 416.907;

(2) The severity of your impairment(s) requires you to purchase (or rent) certain items and services in order to work;

(3) You pay the cost of the item or service. No deduction will be allowed to the extent that payment has been or will be made by another source. No deduction will be allowed to the extent that you have been, could be, or will be reimbursed for such cost by any other source (such as through a private insurance plan, Medicare or Medicaid, or other plan or agency). For example, if you purchase crutches for \$80 but you were, could be, or will be reimbursed \$64 by some agency, plan, or program, we will deduct only \$16;

(4) You pay for the item or service in accordance with paragraph (d) of this section; and

(5) Your payment is in cash (including checks or other forms of money). Payment in kind is not deductible.

(c) *What expenses may be deducted—(1) Payments for attendant care services.* (i) If because of your impairment(s) you need assistance in traveling to and from work, or while at work you need assistance with personal functions (e.g., eating, toileting) or with work-related functions (e.g., reading, communicating), the payments you make for those services may be deducted.

(ii) If because of your impairment(s) you need assistance with personal functions (e.g., dressing, administering medications) at home in preparation for going to and assistance in returning from work, the payments you make for those services may be deducted.

(iii)(A) We will deduct payments you make to a family member for attendant care services only if such person, in order to perform the services, suffers an economic loss by terminating his or her employment or by reducing the number of hours he or she worked.

(B) We consider a family member to be anyone who is related to you by blood, marriage or adoption, whether or not that person lives with you.

(iv) If only part of your payment to a person is for services that come under the provisions of paragraph (c)(1) of this section, we will only deduct that part of the payment which is attributable to those services. For example, an attendant gets you ready for work and helps you in returning from work, which takes about 2 hours a day. The rest of his or her 8 hour day is spent cleaning your house and doing your laundry, etc. We would only deduct one-fourth of the attendant's daily wages as an impairment-related work expense.

(2) *Payments for medical devices.* If your impairment(s) requires that you utilize medical devices in order to work, the payments you make for those devices may be deducted. As used in this subparagraph, medical devices include durable medical equipment which can withstand repeated use, is customarily used for medical purposes, and is generally not useful to a person

in the absence of an illness or injury. Examples of durable medical equipment are wheelchairs, hemodialysis equipment, canes, crutches, inhalators and pacemakers.

(3) *Payments for prosthetic devices.* If your impairment(s) requires that you utilize a prosthetic device in order to work, the payments you make for that device may be deducted. A prosthetic device is that which replaces an internal body organ or external body part. Examples of prosthetic devices are artificial replacements of arms, legs and other parts of the body.

(4) *Payments for equipment—(i) Work-related equipment.* If your impairment(s) requires that you utilize special equipment in order to do your job, the payments you make for that equipment may be deducted. Examples of work-related equipment are one-hand typewriters, telecommunication devices for the deaf and tools specifically designed to accommodate a person's impairment(s).

(ii) *Residential modifications.* If your impairment(s) requires that you make modifications to your residence, the location of your place of work will determine if the cost of these modifications will be deducted. If you are employed away from home, only the cost of changes made outside of your home to permit you to get to your means of transportation (e.g., the installation of an exterior ramp for a wheel-chair confined person or special exterior railings or pathways for someone who requires crutches) will be deducted. Costs relating to modifications of the inside of your home will not be deducted. If you work at home, the costs of modifying the inside of your home in order to create a working space to accommodate your impairment(s) will be deducted to the extent that the changes pertain specifically to the space in which you work. Examples of such changes are the enlargement of a doorway leading into the work space or modification of the work space to accommodate problems in dexterity. However, if you are self-employed at home, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

(iii) *Nonmedical appliances and equipment.* Expenses for appliances and

equipment which you do not ordinarily use for medical purposes are generally not deductible. Examples of these items are portable room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners. However, expenses for such items may be deductible when unusual circumstances clearly establish an impairment-related and medically verified need for such an item because it is essential for the control of your disabling condition, thus enabling you to work. To be considered essential, the item must be of such a nature that if it were not available to you there would be an immediate adverse impact on your ability to function in your work activity. In this situation, the expense is deductible whether the item is used at home or in the working place. An example would be the need for an electric air cleaner by an individual with severe respiratory disease who cannot function in a non-purified air environment. An item such as an exercycle is not deductible if used for general physical fitness. If it is prescribed and used as necessary treatment of your impairment and necessary to enable you to work, we will deduct payments you make toward its cost.

(5) *Payments for drugs and medical services.* (i) If you must use drugs or medical services (including diagnostic procedures) to control your impairment(s), the payments you make for them may be deducted. The drugs or services must be prescribed (or utilized) to reduce or eliminate symptoms of your impairment(s) or to slow down its progression. The diagnostic procedures must be performed to ascertain how the impairment(s) is progressing or to determine what type of treatment should be provided for the impairment(s).

(ii) Examples of deductible drugs and medical services are anticonvulsant drugs to control epilepsy or anticonvulsant blood level monitoring; antidepressant medication for mental disorders; medication used to allay the side effects of certain treatments; radiation treatment or chemotherapy for cancer patients; corrective surgery for spinal disorders; electroencephalograms and brain scans related to a disabling epileptic

condition; tests to determine the efficacy of medication on a diabetic condition; and immunosuppressive medications that kidney transplant patients regularly take to protect against graft rejection.

(iii) We will only deduct the costs of drugs or services that are directly related to your impairment(s). Examples of non-deductible items are routine annual physical examinations, optician services (unrelated to a disabling visual impairment) and dental examinations.

(6) *Payments for similar items and services—(i) General.* If you are required to utilize items and services not specified in paragraph (c)(1) through (5) of this section but which are directly related to your impairment(s) and which you need to work, their costs are deductible. Examples of such items and services are medical supplies and services not discussed above, and transportation.

(ii) *Medical supplies and services not described above.* We will deduct payments you make for expendable medical supplies, such as incontinence pads, catheters, bandages, elastic stockings, face masks, irrigating kits, and disposable sheets and bags. We will also deduct payments you make for physical therapy which you require because of your impairment(s) and which you need in order to work.

(iii) *Payments for transportation costs.* We will deduct transportation costs in these situations:

(A) Your impairment(s) requires that in order to get to work you need a vehicle that has structural or operational modifications. The modifications must be critical to your operation or use of the vehicle and directly related to your impairment(s). We will deduct the costs of the modifications, but not the cost of the vehicle. We will also deduct a mileage allowance for the trip to and from work. The allowance will be based on data compiled by the Federal Highway Administration relating to vehicle operating costs.

(B) Your impairment(s) requires you to use driver assistance, taxicabs or other hired vehicles in order to work. We will deduct amounts paid to the driver and, if your own vehicle is used, we will also deduct a mileage allow-

ance, as provided in paragraph (c)(6)(iii)(A) of this section, for the trip to and from work.

(C) Your impairment(s) prevents your taking available public transportation to and from work and you must drive your (unmodified) vehicle to work. If we can verify through your physician or other sources that the need to drive is caused by your impairment(s) (and not due to the unavailability of public transportation), we will deduct a mileage allowance as provided in paragraph (c)(6)(iii)(A) of this section, for the trip to and from work.

(7) *Payments for installing, maintaining, and repairing deductible items.* If the device, equipment, appliance, etc., that you utilize qualifies as a deductible item as described in paragraphs (c)(2), (3), (4), and (6) of this section, the costs directly related to installing, maintaining and repairing these items are also deductible. (The costs which are associated with modifications to a vehicle are deductible. Except for a mileage allowance, as provided for in paragraph (c)(6)(iii) of this section, the costs which are associated with the vehicle itself are not deductible.)

(d) *When expenses may be deducted—(1) Effective date.* To be deductible an expense must be incurred after November 30, 1980. An expense may be considered incurred after that date if it is paid thereafter even though pursuant to a contract or other arrangement entered into before December 1, 1980.

(2) *Payments for services.* For the purpose of determining SGA, a payment you make for services may be deducted if the services are received while you are working and the payment is made in a month you are working. We consider you to be working even though you must leave work temporarily to receive the services. For the purpose of determining your SSI monthly payment amount, a payment you make for services may be deducted if the payment is made in the month your earned income is received and the earned income is for work done in the month you received the services. If you begin working and make a payment before the month earned income is received, the payment is also deductible. If you make a payment after you stop working, and the payment is made in the

month you received earned income for work done in the month you received the services, the payment is also deductible.

(3) *Payment for items.* For the purpose of determining SGA, a payment you make toward the cost of a deductible item (regardless of when it is acquired) may be deducted if payment is made in a month you are working. For the purpose of determining your SSI monthly payment amount, a payment you make toward the cost of a deductible item (regardless of when it is acquired) may be deducted if the payment is made in the month your earned income is received and the earned income is for work done in the month you used the item. If you begin working and make a payment before the month earned income is received, the payment is also deductible. If you make a payment after you stop working, and the payment is made in the month you received earned income for work done in the month you used the item, the payment is also deductible. See paragraph (e)(4) of this section when purchases are made in anticipation of work.

(e) *How expenses are allocated—(1) Recurring expenses.* You may pay for services on a regular periodic basis, or you may purchase an item on credit and pay for it in regular periodic installments or you may rent an item. If so, each payment you make for the services and each payment you make toward the purchase or rental (including interest) is deductible as described in paragraph (d) of this section.

Example. B starts work in October 1981 at which time she purchases a medical device at a cost of \$4,800 plus interest charges of \$720. Her monthly payments begin in October. She earns and receives \$400 a month. The term of the installment contract is 48 months. No downpayment is made. The monthly allowable deduction for the item would be \$115 (\$5520 divided by 48) for each month of work (for SGA purposes) and for each month earned income is received (for SSI payment purposes) during the 48 months.

(2) *Nonrecurring expenses.* Part or all of your expenses may not be recurring. For example, you may make a one-time payment in full for an item or service or make a downpayment. For the purpose of determining SGA, if you are working when you make the payment we will either deduct the entire

amount in the month you pay it or allocate the amount over a 12 consecutive month period beginning with the month of payment, whichever you select. For the purpose of determining your SSI monthly payment amount, if you are working in the month you make the payment and the payment is made in a month earned income is received, we will either deduct the entire amount in that month, or we will allocate the amount over a 12 consecutive month period, beginning with that month, whichever you select. If you begin working and do not receive earned income in the month you make the payment, we will either deduct or begin allocating the payment amount in the first month you do receive earned income. If you make a payment for services or items after you stopped working, we will deduct the payment if it was made in the month you received earned income for work done in the month you received the services or used the item.

Example. A begins working in October 1981 and earns and receives \$525 a month. In the same month he purchases and pays for a deductible item at a cost of \$250. In this situation we could allow a \$250 deduction for both SGA and SSI payment purposes for October 1981, reducing A's earnings below the SGA level for that month.

If A's earnings had been \$15 above the SGA earnings amount, A probably would select the option of projecting the \$250 payment over the 12-month period, October 1981–September 1982, giving A an allowable deduction of \$20.83 a month for each month of work (for SGA purposes) and for each month earned income is received (for SSI payment purposes) during that period. This deduction would reduce A's earnings below the SGA level for 12 months.

(3) *Allocating downpayments.* If you make a downpayment we will, if you choose, make a separate calculation for the downpayment in order to provide for uniform monthly deductions. In these situations we will determine the total payment that you will make over a 12 consecutive month period beginning with the month of the downpayment and allocate that amount over the 12 months. Beginning with the 13th month, the regular monthly payment will be deductible. This allocation process will be for a shorter period if your regular monthly payments will

extend over a period of less than 12 months.

Example 1. C starts working in October 1981, at which time he purchases special equipment at a cost of \$4,800, paying \$1,200 down. The balance of \$3,600, plus interest of \$540, is to be repaid in 36 installments of \$115 a month beginning November 1981. C earns and receives \$500 a month. He chooses to have the downpayment allocated. In this situation we would allow a deduction of \$205.42 a month for each month of work (for SGA purposes) and for each month earned income is received (for SSI payment purposes) during the period October 1981 through September 1982. After September 1982, the deduction amount would be the regular monthly payment of \$115 for each month of work (for SGA purposes) and for each month earned income is received (for SSI payment purposes) during the remaining installment period.

Explanation:

Downpayment in 10/81	\$1,200
Monthly payments 11/81	
through 09/82	1,265
	12) 2,465
	-\$205.42.

Example 2. D, while working, buys a deductible item in July 1981, paying \$1,450 down. (D earns and receives \$500 a month.) However, his first monthly payment of \$125 is not due until September 1981. D chooses to have the downpayment allocated. In this situation we would allow a deduction of \$225 a month for each month of work (for SGA purposes) and for each month earned income is received (for SSI payment purposes) during the period July 1981 through June 1982. After June 1982, the deduction amount would be the regular monthly payment of \$125 for each month of work (for SGA purposes) and for each month earned income is received (for SSI payment purposes).

Explanation:

Downpayment in 07/81	\$1,450
Monthly payments 09/81	
through 06/82	1,250
	12) 2,700
	-\$225.

(4) *Payments made in anticipation of work.* A payment toward the cost of a deductible item that you made in any of the 11 months preceding the month you started working will be taken into account in determining your impairment-related work expenses. When an item is paid for in full during the 11 months preceding the month you started working the payment will be allocated over the 12-consecutive month period beginning with the month of the payment. However, the only portion of the payment which may be deductible

is the portion allocated to the month work begins and the following months. For example, if an item is purchased 3 months before the month work began and is paid for with a one-time payment of \$600, the deductible amount would be \$450 (\$600 divided by 12, multiplied by 9). Installment payments (including a downpayment) that you made for a particular item during the 11 months preceding the month you started working will be totaled and considered to have been made in the month of your first payment for that item within this 11 month period. The sum of these payments will be allocated over the 12-consecutive month period beginning with the month of your first payment (but never earlier than 11 months before the month work began). However, the only portion of the total which may be deductible is the portion allocated to the month work begins and the following months. For example, if an item is purchased 3 months before the month work began and is paid for in 3 monthly installments of \$200 each, the total payment of \$600 will be considered to have been made in the month of the first payment, that is, 3 months before the month work began. The deductible amount would be \$450 (\$600 divided by 12, multiplied by 9). The amount, as determined by these formulas, will then be considered to have been paid in the first month of work for the purpose of determining SGA and in the first month earned income is received for the purpose of determining the SSI monthly payment amount. For the purpose of determining SGA, we will deduct either the entire amount in the first month of work or allocate it over a 12 consecutive month period beginning with the first month of work, whichever you select. In the above examples, the individual would have the choice of having the entire \$450 deducted in the first month of work or of having \$37.50 a month (\$450 divided by 12) deducted for each month that he works over a 12-consecutive month period, beginning with the first month of work. For the purpose of determining the SSI payment amount, we will either deduct the entire amount in the first month earned income is received or allocate it over a 12-consecutive month period beginning

with the first month earned income is received, whichever you select. In the above examples, the individual would have the choice of having the entire \$450 deducted in the first month earned income is received or of having \$37.50 a month (\$450 divided by 12) deducted for each month he receives earned income (for work) over a 12-consecutive month period, beginning with the first month earned income is received. To be deductible the payments must be for durable items such as medical devices, prostheses, work-related equipment, residential modifications, nonmedical appliances and vehicle modifications. Payments for services and expendable items such as drugs, oxygen, diagnostic procedures, medical supplies and vehicle operating costs are not deductible for purposes of this paragraph.

(f) *Limits on deductions.* (1) We will deduct the actual amounts you pay toward your impairment-related work expenses unless the amounts are unreasonable. With respect to durable medical equipment, prosthetic devices, medical services, and similar medically related items and services, we will apply the prevailing charges under Medicare (part B of title XVIII, Health Insurance for the Aged and Disabled) to the extent that this information is readily available. Where the Medicare guides are used, we will consider the amount that you pay to be reasonable if it is no more than the prevailing charge for the same item or service under the Medicare guidelines. If the amount you actually pay is more than the prevailing charge for the same item under the Medicare guidelines, we will deduct from your earnings the amount you paid to the extent you establish that the amount is consistent with the standard or normal charge for the same or similar item or service in your community. For items and services that are not listed in the Medicare guidelines, and for items and services that are listed in the Medicare guidelines but for which such guides cannot be used because the information is not readily available, we will consider the amount you pay to be reasonable if it does not exceed the standard or normal charge for the same or similar item(s) or service(s) in your community.

(2) Impairment-related work expenses are not deducted in computing your earnings for purposes of determining whether your work was "services" as described in §416.992(b).

(3) The decision as to whether you performed substantial gainful activity in a case involving impairment-related work expenses for items or services necessary for you to work generally will be based upon your "earnings" and not on the value of "services" you rendered. (See §§416.974(b)(6) (i) and (ii), and 416.975(a)). This is not necessarily so, however, if you are in a position to control or manipulate your earnings.

(4) The amount of the expenses to be deducted must be determined in a uniform manner in both the disability insurance and SSI programs. The amount of deductions must, therefore, be the same for determinations as to substantial gainful activity under both programs. The deductions that apply in determining the SSI payment amounts, though determined in the same manner as for SGA determinations, are applied so that they correspond to the timing of the receipt of the earned income to be excluded.

(5) No deduction will be allowed to the extent that any other source has paid or will pay for an item or service. No deduction will be allowed to the extent that you have been, could be, or will be, reimbursed for payments you made. (See paragraph (b)(3) of this section.)

(6) The provisions described in the foregoing paragraphs of this section are effective with respect to expenses incurred on and after December 1, 1980, although expenses incurred after November 1980 as a result of contractual or other arrangements entered into before December 1980, are deductible. For months before December 1980 we will deduct impairment-related work expenses from your earnings only to the extent they exceeded the normal work-related expenses you would have had if you did not have your impairment(s). We will not deduct expenses, however, for those things which you needed even when you were not working.

(g) *Verification.* We will verify your need for items or services for which deductions are claimed, and the amount of the charges for those items or

services. You will also be asked to provide proof that you paid for the items or services.

[48 FR 21940, May 16, 1983]

BLINDNESS

§416.981 Meaning of blindness as defined in the law.

We will consider you blind under the law for payment of supplemental security income benefits if we determine that you are statutorily blind. Statutory blindness is central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.

§416.982 Blindness under a State plan.

We shall also consider you blind for the purposes of payment of supplemental security income benefits if—

(a) You were found to be blind as defined under a State plan approved under title X or title XVI of the Social Security Act, as in effect for October 1972;

(b) You received aid under the State plan because of your blindness for the month of December 1973; and

(c) You continue to be blind as defined under the State plan.

§416.983 How we evaluate statutory blindness.

We will find that you are blind if you are *statutorily blind* within the meaning of §416.981. For us to find that you are statutorily blind, it is not necessary—

(a) That your blindness meet the duration requirement; or

(b) That you be unable to do any substantial gainful activity.

§416.984 If you are statutorily blind and still working.

There is no requirement that you be unable to work in order for us to find that you are blind. However, if you are working, your earnings will be considered under the income and resources rules in subparts K and L of this part. This means that if your income or resources exceed the limitations, you

will not be eligible for benefits, even though you are blind.

§416.985 How we evaluate other visual impairments.

If you are not blind as defined in the law, we will evaluate a visual impairment the same as we evaluate other impairments in determining disability. Although you will not qualify for benefits on the basis of blindness, you may still be eligible for benefits if we find that you are disabled as defined in §§416.905 through 416.907.

§416.986 Why and when we will find that you are no longer entitled to benefits based on statutory blindness.

(a) *If your vision does not meet the definition of blindness.* If you become entitled to payments as a statutorily blind person and your statutory blindness ends, your eligibility for payments generally will end 2 months after your blindness ends. We will find that your statutory blindness has ended beginning with the earliest of the following months—

(1) The month your vision, based on current medical evidence, does not meet the definition of blindness and you were disabled only for a specified period of time in the past;

(2) The month your vision based on current medical evidence, does not meet the definition of blindness, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not now blind; or

(3) The first month in which you fail to follow prescribed treatment that can restore your ability to work (see §416.930).

(b) *If you were found blind as defined in a State plan.* If you become eligible for payments because you were blind as defined in a State plan, we will find that your blindness has ended beginning with the first month in which your vision, as shown by medical or other evidence, does not meet the criteria of the appropriate State plan or the first month in which your vision does not meet the definition of statutory blindness (§416.981), whichever is later, and in neither event earlier than the month in which we mail you a

notice saying that we have determined that you are not now blind under a State plan or not now statutorily blind, as appropriate.

(c) *If you do not cooperate with us.* If you are asked to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your blindness ended if you fail, without good cause, to do what we ask. Section 416.1411 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, §416.918 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your blindness ends will be the month in which you fail to do what we asked.

(d) *Before we stop your payments.* Before we stop payment of your benefits we will give you a chance to give us your reasons why we should not stop payment. Subpart M of this part describes your rights and the procedures we will follow.

[45 FR 55621, Aug. 20, 1980, as amended at 50 FR 50137, Dec. 6, 1985; 51 FR 7603, Feb. 28, 1986; 59 FR 1636, Jan. 12, 1994]

CONTINUING OR STOPPING DISABILITY OR BLINDNESS

§416.988 Your responsibility to tell us of events that may change your disability or blindness status.

If you are entitled to payments because you are disabled or blind, you should promptly tell us if—

- (a) Your condition improves;
- (b) Your return to work;
- (c) You increase the amount of your work; or
- (d) Your earnings increase.

§416.989 We may conduct a review to find out whether you continue to be disabled.

After we find that you are disabled, we must evaluate your impairment(s) from time to time to determine if you are still eligible for payments based on disability. We call this evaluation a continuing disability review. We may begin a continuing disability review for any number of reasons including your failure to follow the provisions of the

Social Security Act or these regulations. When we begin such a review, we will notify you that we are reviewing your eligibility for payments, why we are reviewing your eligibility, that in medical reviews the medical improvement review standard will apply, that our review could result in the termination of your payments, and that you have the right to submit medical and other evidence for our consideration during the continuing disability review. In doing a medical review, we will develop a complete medical history of at least the preceding 12 months in any case in which a determination is made that you are no longer under a disability. If this review shows that we should stop your payments, we will notify you in writing and give you an opportunity to appeal. In §416.990 we describe those events that may prompt us to review whether you continue to be disabled.

[51 FR 16826, May 7, 1986]

§416.989a We may conduct a review to find out whether you continue to be blind.

After we find that you are blind, we must evaluate your impairment(s) from time to time to determine if you are still eligible for payments based on blindness. We call this evaluation a continuing disability review. We may begin a continuing disability review for any number of reasons including your failure to follow the provisions of the Social Security Act or these regulations. When we begin such a review, we will notify you that we are reviewing your eligibility for payments, why we are reviewing your eligibility, that our review could result in the termination of your payments, and that you have the right to submit medical and other evidence for our consideration during the continuing disability review. In doing a medical review, we will develop a complete medical history of at least the preceding 12 months in any case in which a determination is made that you are no longer blind. If this review shows that we should stop your payments, we will notify you in writing and give you an opportunity to appeal. In §416.990 we describe those events

Social Security Administration

that may prompt us to review whether you continue to be blind.

[51 FR 16826, May 7, 1986]

§416.990 When and how often we will conduct a continuing disability review.

(a) *General.* We conduct continuing disability reviews to determine whether or not you continue to meet the disability or blindness requirements of the law. Payment ends if the medical or other evidence shows that you are not disabled or blind as determined under the standards set out in section 1614(a) of the Social Security Act if you receive benefits based on disability or §416.986 of this subpart if you receive benefits based on blindness.

(b) *When we will conduct a continuing disability review.* A continuing disability review will be started if—

(1) You have been scheduled for a medical improvement expected diary review;

(2) You have been scheduled for a periodic review (medical improvement possible or medical improvement not expected) in accordance with the provisions of paragraph (d) of this section;

(3) We need a current medical or other report to see if your disability continues. (This could happen when, for example, an advance in medical technology, such as improved treatment for Alzheimer's disease, or a change in vocational therapy or technology raises a disability issue);

(4) You return to work and successfully complete a period of trial work;

(5) Substantial earnings are reported to your wage record;

(6) You tell us that you have recovered from your disability or that you have returned to work;

(7) Your State Vocational Rehabilitation Agency tells us that—

(i) The services have been completed; or

(ii) You are now working; or

(iii) You are able to work;

(8) Someone in a position to know of your physical or mental condition tells us that you are not disabled or blind, that you are not following prescribed treatment, that you have returned to work, or that you are failing to follow the provisions of the Social Security Act or these regulations, and it appears

that the report could be substantially correct;

(9) Evidence we receive raises a question as to whether your disability or blindness continues; or

(10) You have been scheduled for a vocational reexamination diary review.

(c) *Definitions.* As used in this section—

Medical improvement expected diary—refers to a case which is scheduled for review at a later date because the individual's impairment(s) is expected to improve. Generally, the diary period is set for not less than 6 months or for not more than 18 months. Examples of cases likely to be scheduled for medical improvement expected diary are fractures and cases in which corrective surgery is planned and recovery can be anticipated.

Permanent impairment—medical improvement not expected—refers to a case in which any medical improvement in a person's impairment(s) is not expected. This means an extremely severe condition determined on the basis of our experience in administering the disability programs to be at least static, but more likely to be progressively disabling either by itself or by reason of impairment complications, and unlikely to improve so as to permit the individual to engage in substantial gainful activity. The interaction of the individual's age, impairment consequences and the lack of recent attachment to the labor market may also be considered in determining whether an impairment is permanent. Improvement which is considered temporary under §416.994(b)(2)(iv)(D) or §416.994(c)(2)(iv), as appropriate, will not be considered in deciding if an impairment is permanent. Examples of permanent impairments taken from the list contained in our other written guidelines which are available for public review are as follows and are not intended to be all inclusive:

(1) Parkinsonian Syndrome which has reached the level of severity necessary to meet the Listing in appendix 1 of subpart P or part 404 of this chapter.

(2) Amyotrophic Lateral Sclerosis which has reached the level of severity necessary to meet the Listing in

appendix 1 of subpart P of part 404 of this chapter.

(3) Diffuse pulmonary fibrosis in an individual age 55 or over which has reached the level of severity necessary to meet the Listing in appendix 1 of subpart P of part 404 of this chapter.

(4) Amputation of leg at hip.

Nonpermanent impairment—refers to a case in which any medical improvement in the person's impairment(s) is possible. This means an impairment for which improvement cannot be predicted based on current experience and the facts of the particular case but which is not at the level of severity of an impairment that is considered permanent. Examples of nonpermanent impairments are: Regional enteritis, hyperthyroidism, and chronic ulcerative colitis.

Vocational reexamination diary—refers to a case which is scheduled for review at a later date because the individual is undergoing vocational therapy, training or an educational program which may improve his or her ability to work so that the disability or blindness requirement of the law is no longer met. Generally, the diary period will be set for the length of the training, therapy, or program of education.

(d) *Frequency of review.* If your impairment is expected to improve, generally we will review your continuing eligibility for payments based on disability or blindness at intervals from 6 months to 18 months following our most recent decision. Our notice to you about the review of your case will tell you more precisely when the review will be conducted. If your disability is not considered permanent but is such that any medical improvement in your impairment(s) cannot be accurately predicted, we will review your continuing eligibility for payments at least once every 3 years. If your disability is considered permanent, we will review your continuing eligibility for payments no less frequently than once every 7 years but no more frequently than once every 5 years. Regardless of your classification we will conduct an immediate continuing disability review if a question of continuing disability is raised pursuant to paragraph (b) of this section.

(e) *Change in classification of impairment.* If the evidence developed during a continuing disability review demonstrates that your impairment has improved, is expected to improve, or has worsened since the last review, we may reclassify your impairment to reflect this change in severity. A change in the classification of your impairment will change the frequency with which we will review your case. We may also reclassify certain impairments because of improved tests, treatment, and other technical advances concerning those impairments.

(f) *Review after administrative appeal.* If you were found eligible to receive or to continue to receive, payments on the basis of a decision by an administrative law judge, the Appeals Council or a Federal court, we will not conduct a continuing disability review earlier than 3 years after that decision unless your case should be scheduled for a medical improvement expected or vocational reexamination diary review or a question of continuing disability is raised pursuant to paragraph (b) of this section.

(g) *Waiver of timeframes.* All cases involving a nonpermanent impairment will be reviewed by us at least once every 3 years unless we, after consultation with the State agency, determine that the requirement should be waived to ensure that only the appropriate number of cases are reviewed. The appropriate number of cases to be reviewed is to be based on such considerations as the backlog of pending reviews, the projected number of new applications, and projected staffing levels. Such waiver shall be given only after good faith effort on the part of the State to meet staffing requirements and to process the reviews on a timely basis. Availability of independent medical resources may also be a factor. A waiver in this context refers to our administrative discretion to determine the appropriate number of cases to be reviewed on a State by State basis. Therefore, your continuing disability review may be delayed longer than 3 years following our original decision or other review under certain circumstances. Such a delay would be based on our need to ensure that backlogs, reviews required to be

performed by the Social Security Disability Benefits Reform Act (Pub. L. 98-460), and new disability claims workloads are accomplished within available medical and other resources in the State agency and that such reviews are done carefully and accurately.

[51 FR 16826, May 7, 1986]

\$416.991 If your medical recovery was expected and you returned to work.

If your impairment was expected to improve and you returned to full-time work with no significant medical limitations and acknowledge that medical improvement has occurred, we may find that your disability ended in the month you returned to work. Unless there is evidence showing that your disability has not ended, we will use the medical and other evidence already in your file and the fact that you returned to full-time work without significant limitations to determine that you are no longer disabled. (If your impairment is not expected to improve, we will not ordinarily review your claim until the end of the trial work period, as described in §416.992).

Example: Evidence obtained during the processing of your claim showed that you had an impairment that was expected to improve about 18 months after your disability began. We, therefore, told you that your claim would be reviewed again at that time. However, before the time arrived for your scheduled medical re-examination, you told us that you had returned to work and your impairment had improved. We reviewed your claim immediately and found that, in the 18th month after your disability began, you returned to full-time work without any significant medical restrictions. Therefore, we would find that your disability ended in the first month you returned to full-time work.

[50 FR 50137, Dec. 6, 1985]

\$416.992 The trial work period.

(a) *Definition of the trial work period.* The trial work period is a period during which you may test your ability to work and still be considered disabled. It begins and ends as described in paragraph (e) of this section. During this period, you may perform services (see paragraph (b) of this section) in as many as 9 months, but these months do not have to be consecutive. We will not consider those services as showing that

your disability has ended until you have performed services in at least 9 months. However, during this trial work period we will evaluate your earnings under the income and resources rules in subparts K and L of this part. This means that if your income or resources exceed the limitations, you will not be eligible for payments even though you have not worked a full 9 months. (See paragraph (e) of this section.) After the trial work period has ended we will consider the work you did during the trial work period in determining whether your disability ended at any time after the trial work period.

(b) *What we mean by services.* When used in this section, services means any activity, even though it is not substantial gainful activity, which is done by a person in employment or self-employment for pay or profit, or is the kind normally done for pay or profit. If you are an employee, we will consider your work to be services if in any calendar year after 1978 you earn more than \$75 a month (\$50 a month is the figure for earnings in any calendar year before 1979). If you are self-employed, we will consider your activities services if in any calendar year after 1978 your net earnings are more than \$75 a month (\$50 a month is the figure for earnings in any calendar year before 1979), or you work more than 15 hours a month in the business. We generally do not consider work to be services when it is done without remuneration or merely as therapy or training, or when it is work usually done in a daily routine around the house or in self-care.

(c) *Limitations on the number of trial work periods.* You may have only one trial work period during a period of entitlement to cash payments.

(d) *When the trial work period begins and ends.* The trial work period begins with the month in which you become entitled to benefits. It cannot begin before the month in which you file your application for benefits. It ends with the close of whichever of the following calendar months is the earlier:

(1) The 9th month (whether or not the months have been consecutive) in which you have performed services; or

(2) The month in which new evidence, other than evidence relating to any

work you did during the trial work period, shows that you are not disabled, even though you have not worked a full 9 months. We may find that your disability has ended at any time during the trial work period if the medical or other evidence shows that you are no longer disabled (see §416.994).

(e) *If you fail to meet other eligibility factors.* We will count the services you do while disabled towards your period of trial work even though you may be ineligible for payments for other reasons. The months in which you are eligible for payments will be evaluated for trial work purposes upon reestablishment of your eligibility for payments under this part as though your eligibility had not been interrupted.

[45 FR 55621, Aug. 20, 1980, as amended at 50 FR 50137, Dec. 6, 1985; 51 FR 16015, Apr. 30, 1986]

§416.992a The reentitlement period.

(a) *General.* The reentitlement period is an additional period after 9 months of trial work during which you may continue to test your ability to work if you have a disabling impairment.

Generally, you will not be paid benefits for any month, after the third month, in this period in which you do substantial gainful activity unless you qualify for the special benefits explained in §416.261. You will be paid benefits for months in which you do not do substantial gainful activity and you meet all the other eligibility requirements. (See §416.1331.) If your benefits are stopped because you do substantial gainful activity they may be started again without a new application and a new determination of disability if you discontinue doing substantial gainful activity during this period. In determining, for reentitlement benefit purposes, whether you do SGA in a month during the reentitlement period we only consider your work in or earnings for that month; we do not consider the average amount of your work or earnings over a period of months.

(b) *When the reentitlement period begins and ends.* The reentitlement period begins with the first month following completion of 9 months of trial work but cannot begin earlier than Decem-

ber 1, 1980. It ends with whichever is earlier—

(1) The month before the first month in which your impairment is determined to no longer exist or not to be disabling; or

(2) The last day of the 15th month following the end of your trial work period. (See §416.1331 for when your benefits end.)

[49 FR 22274, May 29, 1984]

§416.993 Medical evidence in continuing disability review cases.

(a) *General.* If you are entitled to benefits because you are disabled, we will have your case file with the supporting medical evidence previously used to establish or continue your entitlement. Generally, therefore, the medical evidence we will need for a continuing disability review will be that required to make a current determination or decision as to whether you are still disabled, as defined under the medical improvement review standard. See §§416.979 and 416.994.

(b) *Obtaining evidence from your medical sources.* You must provide us with reports from your physician, psychologist, or others who have treated or evaluated you, as well as any other evidence that will help us determine if you are still disabled. See §416.912. You must have a good reason for not giving us this information or we may find that your disability has ended. See §416.994(e)(2). If we ask you, you must contact your medical sources to help us get the medical reports. We will make every reasonable effort to help you in getting medical reports when you give us permission to request them from your physician, psychologist, or other medical sources. See §416.912(d)(1) concerning what we mean by every reasonable effort. In some instances, such as when a source is known to be unable to provide certain tests or procedures or is known to be nonproductive or uncooperative, we may order a consultative examination while awaiting receipt of medical source evidence. Before deciding that your disability has ended, we will develop a complete medical history covering at least the 12 months preceding the date you sign a report about your

continuing disability status. See §416.912(c).

(c) *When we will purchase a consultative examination.* A consultative examination may be purchased when we need additional evidence to determine whether or not your disability continues. As a result, we may ask you, upon our request and reasonable notice, to undergo consultative examinations and tests to help us determine if you are still disabled. See §416.917. We will decide whether or not to purchase a consultative examination in accordance with the standards in §§416.919a through 416.919b.

[56 FR 36970, Aug. 1, 1991]

§416.994 How we will determine whether your disability continues or ends.

(a) *General.* There is a statutory requirement that, if you are entitled to disability benefits, your continued entitlement to such benefits must be reviewed periodically. Our rules for deciding whether your disability continues are set forth in paragraph (b) of this section. Additional rules apply if you were found disabled under a State plan, as set forth in paragraph (c) of this section.

(b) *Disabled persons age 18 or over (adults).* If you are entitled to disability benefits as a disabled person age 18 or over (adult) there are a number of factors we consider in deciding whether your disability continues. We must determine if there has been any medical improvement in your impairment(s) and, if so, whether this medical improvement is related to your ability to work. If your impairment(s) has not so medically improved, we must consider whether one or more of the exceptions to medical improvement applies. If medical improvement related to your ability to work has not occurred and no exception applies, your benefits will continue. Even where medical improvement related to your ability to work has occurred or an exception applies, in most cases, (see paragraph (b)(4) of this section for exceptions) we must also show that you are currently able to engage in substantial gainful activity before we can find that you are no longer disabled.

(1) *Terms and definitions.* There are several terms and definitions which are important to know in order to understand how we review whether your disability continues.

(i) *Medical improvement.* Medical improvement is any decrease in the medical severity of your impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on changes (improvement) in the symptoms, signs and/or laboratory findings associated with your impairment(s) (see §416.928).

Example 1: You were awarded disability benefits due to a herniated nucleus pulposus. At the time of our prior decision granting you benefits you had had a laminectomy. Postoperatively, a myelogram still shows evidence of a persistent deficit in your lumbar spine. You had pain in your back, and pain and a burning sensation in your right foot and leg. There were no muscle weakness or neurological changes and a modest decrease in motion in your back and leg. When we reviewed your claim your treating physician reported that he had seen you regularly every 2 to 3 months for the past 2 years. No further myelograms had been done, complaints of pain in the back and right leg continued especially on sitting or standing for more than a short period of time. Your doctor further reported a moderately decreased range of motion in your back and right leg, but again no muscle atrophy or neurological changes were reported. Medical improvement has not occurred because there has been no decrease in the severity of your back impairment as shown by changes in symptoms, signs or laboratory findings.

Example 2: You were awarded disability benefits due to rheumatoid arthritis. At the time, laboratory findings were positive for this condition. Your doctor reported persistent swelling and tenderness of your fingers and wrists and that you complained of joint pain. Current medical evidence shows that while laboratory tests are still positive for rheumatoid arthritis, your impairment has responded favorably to therapy so that for the last year your fingers and wrists have not been significantly swollen or painful. Medical improvement has occurred because there has been a decrease in the severity of your impairment as documented by the current symptoms and signs reported by your physician. Although your impairment is subject to temporary remissions and exacerbations, the improvement that has occurred has been sustained long enough to permit a finding of medical improvement. We would

then determine if this medical improvement is related to your ability to work.

(ii) *Medical improvement not related to ability to do work.* Medical improvement is not related to your ability to work if there has been a decrease in the severity of the impairment(s) as defined in paragraph (b)(1)(i) of this section, present at the time of the most recent favorable medical decision, but no increase in your functional capacity to do basic work activities as defined in paragraph (b)(1)(iv) of this section. If there has been any medical improvement in your impairment(s), but it is not related to your ability to do work and none of the exceptions applies, your benefits will be continued.

Example: You are 65 inches tall and weighed 246 pounds at the time your disability was established. You had venous insufficiency and persistent edema in your legs. At the time, your ability to do basic work activities was affected because you were able to sit for 6 hours, but were able to stand or walk only occasionally. At the time of our continuing disability review, you had undergone a vein stripping operation. You now weigh 220 pounds and have intermittent edema. You are still able to sit for 6 hours at a time and to stand or walk only occasionally although you report less discomfort on walking. Medical improvement has occurred because there has been a decrease in the severity of the existing impairment as shown by your weight loss and the improvement in your edema. This medical improvement is not related to your ability to work, however, because your functional capacity to do basic work activities (i.e., the ability to sit, stand and walk) has not increased.

(iii) *Medical improvement that is related to ability to do work.* Medical improvement is related to your ability to work if there has been a decrease in the severity, as defined in paragraph (b)(1)(i) of this section, of the impairment(s) present at the time of the most recent favorable medical decision and an increase in your functional capacity to do basic work activities as discussed in paragraph (b)(1)(iv) of this section. A determination that medical improvement related to your ability to do work has occurred does not, necessarily, mean that your disability will be found to have ended unless it is also shown that you are currently able to engage in substantial gainful activity as discussed in paragraph (b)(1)(v) of this section.

Example 1: You have a back impairment and had a laminectomy to relieve the nerve root impingement and weakness in your left leg. At the time of our prior decision, basic work activities were affected because you were able to stand less than 6 hours, and sit no more than ½ hour at a time. You had a successful fusion operation on your back about 1 year before our review of your entitlement. At the time of our review, the weakness in your leg has decreased. Your functional capacity to perform basic work activities now is unimpaired because you now have no limitation on your ability to sit, walk, or stand. Medical improvement has occurred because there has been a decrease in the severity of your impairment as demonstrated by the decreased weakness in your leg. This medical improvement is related to your ability to work because there has also been an increase in your functional capacity to perform basic work activities (or residual functional capacity) as shown by the absence of limitation on your ability to sit, walk, or stand. Whether or not your disability is found to have ended, however, will depend on our determination as to whether you can currently engage in substantial gainful activity.

Example 2: You were injured in an automobile accident receiving a compound fracture to your right femur and a fractured pelvis. When you applied for disability benefits 10 months after the accident your doctor reported that neither fracture had yet achieved solid union based on his clinical examination. X-rays supported this finding. Your doctor estimated that solid union and a subsequent return to full weight bearing would not occur for at least 3 more months. At the time of our review 6 months later, solid union had occurred and you had been returned to weight-bearing for over a month. Your doctor reported this and the fact that your prior fractures no longer placed any limitation on your ability to walk, stand, lift, etc., and, that in fact, you could return to fulltime work if you so desired.

Medical improvement has occurred because there has been a decrease in the severity of your impairments as shown by X-ray and clinical evidence of solid union and your return to full weight-bearing. This medical improvement is related to your ability to work because you no longer meet the same listed impairment in appendix 1 of subpart P of part 404 of this chapter (see paragraph (b)(2)(iii)(A) of this section). In fact, you no longer have an impairment which is severe (see §416.921) and your disability will be found to have ended.

(iv) *Functional capacity to do basic work activities.* Under the law, disability is defined, in part, as the inability to do any substantial gainful activity by reason of any medically

determinable physical or mental impairment(s). In determining whether you are disabled under the law, we must measure, therefore, how and to what extent your impairment(s) has affected your ability to do work. We do this by looking at how your functional capacity for doing basic work activities has been affected. Basic work activities means the abilities and aptitudes necessary to do most jobs. Included are exertional abilities such as walking, standing, pushing, pulling, reaching and carrying, and nonexertional abilities and aptitudes such as seeing, hearing, speaking, remembering, using judgment, dealing with changes and dealing with both supervisors and fellow workers. A person who has no impairment(s) would be able to do all basic work activities at normal levels; he or she would have an unlimited functional capacity to do basic work activities. Depending on its nature and severity, an impairment will result in some limitation to the functional capacity to do one or more of these basic work activities. Diabetes, for example, can result in circulatory problems which could limit the length of time a person could stand or walk and damage to his or her eyes as well, so that the person also had limited vision. What a person can still do despite an impairment, is called his or her residual functional capacity. How the residual functional capacity is assessed is discussed in more detail in §416.945. Unless an impairment is so severe that it is deemed to prevent you from doing substantial gainful activity (see §§416.925 and 416.926) it is this residual functional capacity that is used to determine whether you can still do your past work or, in conjunction with your age, education and work experience, any other work.

(A) A decrease in the severity of an impairment as measured by changes (improvement) in symptoms, signs or laboratory findings can, if great enough, result in an increase in the functional capacity to do work activities. Vascular surgery (e.g., femoropopliteal bypass) may sometimes reduce the severity of the circulatory complications of diabetes so that better circulation results and the person can stand or walk for longer pe-

riods. When new evidence showing a change in symptoms, signs and laboratory findings establishes that both medical improvement has occurred and your functional capacity to perform basic work activities, or residual functional capacity, has increased, we say that medical improvement which is related to your ability to do work has occurred. A residual functional capacity assessment is also used to determine whether you can engage in substantial gainful activity and, thus, whether you continue to be disabled (see paragraph (b)(1)(vi) of this section).

(B) Many impairment-related factors must be considered in assessing your functional capacity for basic work activities. Age is one key factor. Medical literature shows that there is a gradual decrease in organ function with age; that major losses and deficits become irreversible over time and that maximum exercise performance diminishes with age. Other changes related to sustained periods of inactivity and the aging process include muscle atrophy, degenerative joint changes, decrease in range of motion, and changes in the cardiac and respiratory systems which limit the exertional range.

(C) Studies have also shown that the longer an individual is away from the workplace and is inactive, the more difficult it becomes to return to ongoing gainful employment. In addition, a gradual change occurs in most jobs so that after about 15 years, it is no longer realistic to expect that skills and abilities acquired in these jobs will continue to apply to the current workplace. Thus, if you are age 50 or over and have been receiving disability benefits for a considerable period of time, we will consider this factor along with your age in assessing your residual functional capacity. This will ensure that the disadvantages resulting from inactivity and the aging process during a long period of disability will be considered. In some instances where available evidence does not resolve what you can or cannot do on a sustained basis, we will provide special work evaluations or other appropriate testing.

(v) *Ability to engage in substantial gainful activity.* In most instances, we must show that you are able to engage

in substantial gainful activity before your benefits are stopped. When doing this, we will consider all your current impairments not just that impairment(s) present at the time of the most recent favorable determination. If we cannot determine that you are still disabled based on medical consideration alone (as discussed in §§416.925 and 416.926), we will use the new symptoms, signs and laboratory findings to make an objective assessment of your functional capacity to do basic work activities or residual functional capacity and we will consider your vocational factors. See §§416.945 through 416.969.

(vi) *Evidence and basis for our decision.* Our decisions under this section will be made on a neutral basis without any initial inference as to the presence or absence of disability being drawn from the fact that you have previously been determined to be disabled. We will consider all evidence you submit, as well as all evidence we obtain from your treating physician(s) and other medical or nonmedical sources. What constitutes "evidence" and our procedures for obtaining it are set out in §§416.912 through 416.918. Our determination regarding whether your disability continues will be made on the basis of the weight of the evidence.

(vii) *Point of comparison.* For purpose of determining whether medical improvement has occurred, we will compare the current medical severity of that impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled to the medical severity of that impairment(s) at that time. If medical improvement has occurred, we will compare your current functional capacity to do basic work activities (i.e., your residual functional capacity) based on the previously existing impairments with your prior residual functional capacity in order to determine whether the medical improvement is related to your ability to do work. The most recent favorable medical decision is the latest decision involving a consideration of the medical evidence and the issue of whether you were disabled or continued to be disabled which became final.

(2) *Determining medical improvement and its relationship to your abilities to do work.* Paragraphs (b)(1)(i) through (b)(1)(iii) of this section discuss what we mean by medical improvement, medical improvement not related to your ability to work, and medical improvement that is related to your ability to work. How we will arrive at the decision that medical improvement has occurred and its relationship to the ability to do work, is discussed below.

(i) *Medical improvement.* Medical improvement is any decrease in the medical severity of impairment(s) present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled and is determined by a comparison of prior and current medical evidence which must show that there have been changes (improvement) in the symptoms, signs or laboratory findings associated with that impairment(s).

(ii) *Determining if medical improvement is related to ability to work.* If there is a decrease in medical severity as shown by the symptoms, signs and laboratory findings, we then must determine if it is related to your ability to do work. In paragraph (b)(1)(iv) of this section, we explain the relationship between medical severity and limitation on functional capacity to do basic work activities (or residual functional capacity) and how changes in medical severity can affect your residual functional capacity. In determining whether medical improvement that has occurred is related to your ability to do work, we will assess your residual functional capacity (in accordance with paragraph (b)(1)(iv) of this section) based on the current severity of the impairment(s) which was present at your last favorable medical decision.

(iii) Your new residual functional capacity will then be compared to your residual functional capacity at the time of our most recent favorable medical decision. Unless an increase in the current residual functional capacity is based on actual changes in the signs, symptoms, or laboratory findings any medical improvement that has occurred will not be considered to be related to your ability to do work.

(iv) Following are some additional factors and considerations which we

will apply in making these determinations.

(A) *Previous impairment met or equaled listings.* If our most recent favorable decision was based on the fact that your impairment(s) at the time met or equaled the severity contemplated by the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter, an assessment of your residual functional capacity would not have been made. If medical improvement has occurred and the severity of the prior impairment(s) no longer meets or equals the same listing section used to make our most recent favorable decision, we will find that the medical improvement was related to your ability to work. Appendix 1 of subpart P of part 404 of this chapter describes impairments which, if severe enough, affect a person's ability to work. If the appendix level severity is met or equaled the individual is deemed, in the absence of evidence to the contrary, to be unable to engage in gainful activity. If there has been medical improvement to the degree that the requirement of the listing section is no longer met or equaled, then the medical improvement is related to your ability to work. We must, of course, also establish that you can currently engage in substantial gainful activity before finding that your disability has ended.

(B) *Prior residual functional capacity assessment made.* The residual functional capacity assessment used in making the most recent favorable medical decision will be compared to the residual functional capacity assessment based on current evidence in order to determine if your functional capacity for basic work activities has increased. There will be no attempt made to reassess the prior residual functional capacity.

(C) *Prior residual functional capacity assessment should have been made, but was not.* If the most recent favorable medical decision should have contained an assessment of your residual functional capacity (i.e., your impairments did not meet or equal the level of severity contemplated by the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter) but does not, either because this assessment is

missing from your file or because it was not done, we will reconstruct the residual functional capacity. This reconstructed residual functional capacity will accurately and objectively assess your functional capacity to do basic work activities. We will assign the maximum functional capacity consistent with a decision of allowance.

Example: You were previously found to be disabled on the basis that "while your impairment did not meet or equal a listing, it did prevent you from doing your past or any other work." The prior adjudicator did not, however, include a residual functional capacity assessment in the rationale of this decision and a review of the prior evidence does not show that such an assessment was ever made. If a decrease in medical severity, i.e., medical improvement, has occurred, the residual functional capacity based on the current level of severity of your impairment will have to be compared with your residual functional capacity based on its prior severity in order to determine if the medical improvement is related to your ability to do work. In order to make this comparison, we will review the prior evidence and make an objective assessment of your residual functional capacity at the time of our most recent favorable medical determination, based on the symptoms, signs and laboratory findings as they then existed.

(D) *Impairment subject to temporary remission.* In some cases the evidence shows that an individual's impairments are subject to temporary remission. In assessing whether medical improvement has occurred in persons with this type of impairment, we will be careful to consider the longitudinal history of the impairment, including the occurrence of prior remission, and prospects for future worsenings. Improvement in such impairments that is only temporary will not warrant a finding of medical improvement.

(E) *Prior file cannot be located.* If the prior file cannot be located, we will first determine whether you are able to now engage in substantial gainful activity based on all your current impairments. (In this way, we will be able to determine that your disability continues at the earliest point without addressing the often lengthy process of reconstructing prior evidence.) If you cannot engage in substantial gainful activity currently, your benefits will continue unless one of the second group of exceptions applies (see

paragraph (b)(4) of this section). If you are able to engage in substantial gainful activity, we will determine whether an attempt should be made to reconstruct those portions of the missing file that were relevant to our most recent favorable medical decision (e.g., work history, medical evidence from treating sources and the results of consultative examinations). This determination will consider the potential availability of old records in light of their age, whether the source of the evidence is still in operation, and whether reconstruction efforts will yield a complete record of the basis for the most recent favorable medical decision. If relevant parts of the prior record are not reconstructed either because it is determined not to attempt reconstruction or because such efforts fail, medical improvement cannot be found. The documentation of your current impairments will provide a basis for any future reviews. If the missing file is later found, it may serve as a basis for reopening any decision under this section in accordance with §416.988.

(3) *First group of exceptions to medical improvement.* The law provides for certain limited situations when your disability can be found to have ended even though medical improvement has not occurred, if you can engage in substantial gainful activity. These exceptions to medical improvement are intended to provide a way of finding that a person is no longer disabled in those limited situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the person should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, we must also show that, taking all your current impairment(s) into account, not just those that existed at the time of our most recent favorable medical decision, you are now able to engage in substantial gainful activity before your disability can be found to have ended. As part of the review process, you will be asked about any medical or vocational therapy you received or are receiving. Your answers and the evidence gathered as a result as well as all other

evidence, will serve as the basis for the finding that an exception applies.

(i) *Substantial evidence shows that you are the beneficiary of advances in medical or vocational therapy or technology (related to your ability to work).* Advances in medical or vocational therapy or technology are improvements in treatment or rehabilitative methods which have increased your ability to do basic work activities. We will apply this exception when substantial evidence shows that you have been the beneficiary of services which reflect these advances and they have favorably affected the severity of your impairment or your ability to do basic work activities. This decision will be based on new medical evidence and a new residual functional capacity assessment. (See §416.945.) This exception does not apply if you are eligible to receive special Supplemental Security Income cash benefits as explained in §416.261. In many instances, an advanced medical therapy or technology will result in a decrease in severity as shown by symptoms, signs and laboratory findings which will meet the definition of medical improvement. This exception will, therefore, see very limited application.

(ii) *Substantial evidence shows that you have undergone vocational therapy (related to your ability to work).* Vocational therapy (related to your ability to work) may include, but is not limited to, additional education, training, or work experience that improves your ability to meet the vocational requirements of more jobs. This decision will be based on substantial evidence which includes new medical evidence and a new residual functional capacity assessment. (See §416.945.) This exception does not apply if you are eligible to receive special Supplemental Security Income cash benefits as explained in §416.261. If, at the time of our review, you have not completed vocational therapy which could affect the continuance of your disability, we will review your claim upon completion of the therapy.

Example 1: You were found to be disabled because the limitations imposed on you by your impairment allowed you to only do work that was at a sedentary level of exertion. Your prior work experience was work that required a medium level of exertion. Your age and education at the time would

not have qualified you for work that was below this medium level of exertion. You enrolled in and completed a specialized training course which qualifies you for a job in data processing as a computer programmer in the period since you were awarded benefits. On review of your claim, current evidence shows that there is no medical improvement and that you can still do only sedentary work. As the work of a computer programmer is sedentary in nature, you are now able to engage in substantial gainful activity when your new skills are considered.

Example 2: You were previously entitled to benefits because the medical evidence and assessment of your residual functional capacity showed you could only do light work. Your prior work was considered to be heavy in nature and your age, education and the nature of your prior work qualified you for work which was no less than medium in exertion. The current evidence and residual functional capacity show there has been no medical improvement and that you can still do only light work. Since you were originally entitled to benefits, your vocational rehabilitation agency enrolled you in and you successfully completed a trade school course so that you are now qualified to do small appliance repair. This work is light in nature, so when your new skills are considered, you are now able to engage in substantial gainful activity even though there has been no change in your residual functional capacity.

(iii) *Substantial evidence shows that based on new or improved diagnostic or evaluative techniques your impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.* Changing methodologies and advances in medical and other diagnostic or evaluative techniques have given, and will continue to give, rise to improved methods for measuring and documenting the effect of various impairments on the ability to do work. Where, by such new or improved methods, substantial evidence shows that your impairment(s) is not as severe as was determined at the time of our most recent favorable medical decision, such evidence may serve as a basis for finding that you are no longer disabled, if you can currently engage in substantial gainful activity. In order to be used under this exception, however, the new or improved techniques must have become generally available after the date of our most recent favorable medical decision.

(A) *How we will determine which methods are new or improved techniques and*

when they become generally available. New or improved diagnostic techniques or evaluations will come to our attention by several methods. In reviewing cases, we often become aware of new techniques when their results are presented as evidence. Such techniques and evaluations are also discussed and acknowledged in medical literature by medical professional groups and other governmental entities. Through these sources, we develop listings of new techniques and when they become generally available. For example, we will consult the Health Care Financing Administration for its experience regarding when a technique is recognized for payment under Medicare and when they began paying for the technique.

(B) *How you will know which methods are new or improved techniques and when they become generally available.* We will let you know which methods we consider to be new or improved techniques and when they become available through two vehicles.

(1) Some of the future changes in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter will be based on new or improved diagnostic or evaluation techniques. Such listings changes will clearly state this fact as they are published as Notices of Proposed Rulemaking and the new or improved techniques will be considered generally available as of the date of the final publication of that particular listing in the FEDERAL REGISTER.

(2) A cumulative list since 1970 of new or approved diagnostic techniques or evaluations, how they changed the evaluation of the applicable impairment and the month and year they became generally available, will be published in the Notices section of the FEDERAL REGISTER. Included will be any changes in the Listing of Impairments published in the Code of Federal Regulations since 1970 which are reflective of new or improved techniques. No cases will be processed under this exception until this cumulative listing is so published. Subsequent changes to the list will be published periodically. The period will be determined by the volume of changes needed.

Example: The electrocardiographic exercise test has replaced the Master's 2-step test as a measurement of heart function since the

time of your last favorable medical decision. Current evidence could show that your condition, which was previously evaluated based on the Master's 2-step test, is not now as disabling as was previously thought. If, taking all your current impairments into account, you are now able to engage in substantial gainful activity, this exception would be used to find that you are no longer disabled even if medical improvement has not occurred.

(iv) *Substantial evidence demonstrates that any prior disability decision was in error.* We will apply the exception to medical improvement based on error if substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) demonstrates that a prior determination was in error. A prior determination will be found in error only if:

(A) Substantial evidence shows on its face that the decision in question should not have been made (e.g., the evidence in your file such as pulmonary function study values was misread or an adjudicative standard such as a listing in appendix 1 of subpart P of part 404 of this chapter or a medical/vocational rule in appendix 2 of subpart P of part 404 of this chapter was misapplied).

Example 1: You were granted benefits when it was determined that your epilepsy met Listing 11.02. This listing calls for a finding of major motor seizures more frequently than once a month as documented by electroencephalogram evidence and by a detailed description of a typical seizure pattern. A history of either diurnal episodes or nocturnal episodes with residuals interfering with daily activities is also required. On review, it is found that a history of the frequency of your seizures showed that they occurred only once or twice a year. The prior decision would be found to be in error, and whether you were still considered to be disabled would be based on whether you could currently engage in substantial gainful activity.

Example 2: Your prior award of benefits was based on vocational rule 201.12 in appendix 2 of subpart P of part 404 of this chapter. This rule applies to a person age 50-54 who has at least a high school education, whose previous work was entirely at a semiskilled level, and who can do only sedentary work. On review, it is found that at the time of the prior determination you were actually only age 46 and vocational rule 201.21 should have

been used. This rule would have called for a denial of your claim and the prior decision is found to have been in error. Continuation of your disability would depend on a finding of your current ability to engage in substantial gainful activity.

(B) At the time of the prior evaluation, required and material evidence of the severity of your impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that had such evidence been present at the time of the prior determination, disability would not have been found.

Example: You were found disabled on the basis of chronic obstructive pulmonary disease. The severity of your impairment was documented primarily by pulmonary function testing results. The evidence showed that you could do only light work. Spirometric tracings of this testing, although required, were not obtained, however. On review, the original report is resubmitted by the consultative examining physician along with the corresponding spirometric tracings. A review of the tracings shows that the test was invalid. Current pulmonary function testing supported by spirometric tracings reveals that your impairment does not limit your ability to perform basic work activities in any way. Error is found based on the fact that required, material evidence which was originally missing now becomes available and shows that if it had been available at the time of the prior determination, disability would not have been found.

(C) Substantial evidence which is new evidence which relates to the prior determination (of allowance or continuance) refutes the conclusions that were based upon the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that had the new evidence, (which relates to the prior determination) been considered at the time of the prior decision, the claim would not have been allowed or continued. A substitution of current judgment for that used in the prior favorable decision will not be the basis for applying this exception.

Example: You were previously found entitled to benefits on the basis of diabetes mellitus which the prior adjudicator believed was equivalent to the level of severity contemplated in the Listing of Impairments. The prior record shows that you had "brittle" diabetes for which you were taking insulin. Your urine was 3+ for sugar, and you alleged occasional hypoglycemic attacks

caused by exertion. On review, symptoms, signs and laboratory findings are unchanged. The current adjudicator feels, however, that your impairment clearly does not equal the severity contemplated by the listings. Error cannot be found because it would represent a substitution of current judgment for that of the prior adjudicator that your impairment equaled a listing.

(D) The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision (see §§416.1488 through 416.1489) are met.

(v) *You are currently engaging in substantial gainful activity.* If you are currently engaging in substantial gainful activity before we determine whether you are no longer disabled because of your work activity, we will consider whether you are entitled to a trial work period as set out in §416.992. We will find that your disability has ended in the month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period, where it applies). This exception does not apply if you are eligible to receive special Supplemental Security Income cash benefits as explained in §416.261. This exception also does not apply in determining whether you continue to have a disabling impairment(s) (§416.911) for purposes of deciding your eligibility for a reentitlement period (§416.992a).

(4) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination that you are no longer disabled. In these situations the decision will be made without a determination that you have medically improved or can engage in substantial gainful activity.

(i) *A prior determination or decision was fraudulently obtained.* If we find that any prior favorable determination or decision was obtained by fraud, we may find that you are not disabled. In addition, we may reopen your claim under the rules in §416.1488. In determining whether a prior favorable determination or decision was fraudulently obtained, we will take into account any physical, mental, educational, or linguistic limitations (including any

lack of facility with the English language) which you may have had at the time.

(ii) *You do not cooperate with us.* If there is a question about whether you continue to be disabled and we ask you to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 416.1411 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, §416.918 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability ends will be the first month in which you failed to do what we asked.

(iii) *We are unable to find you.* If there is a question about whether you continue to be disabled and we are unable to find you to resolve the question, we will suspend your payments. The month your payments are suspended will be the first month in which the question arose and we could not find you.

(iv) *You fail to follow prescribed treatment which would be expected to restore your ability to engage in substantial gainful activity.* If treatment has been prescribed for you which would be expected to restore your ability to work, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have good cause for failing to follow that treatment, we will find that your disability has ended (see §416.930(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

(5) *Evaluation steps.* To assure that disability reviews are carried out in a uniform manner, that a decision of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally and are fully documented, we will follow specific steps in reviewing the question of whether your disability continues. Our review may cease and benefits may be continued at any point if we determine

there is sufficient evidence to find that you are still unable to engage in substantial gainful activity. The steps are:

(i) Are you engaging in substantial gainful activity? If you are (and any applicable trial work period has been completed), we will find disability to have ended (see paragraph (b)(3)(v) of this section).

(ii) If you are not, do you have an impairment or combination of impairments which meets or equals the severity of an impairment listed in appendix 1 of subpart P of part 404 of this chapter? If you do, your disability will be found to continue.

(iii) If you do not, has there been medical improvement as defined in paragraph (b)(1)(i) of this section? If there has been medical improvement as shown by a decrease in medical severity, see step (iv). If there has been no decrease in medical severity, there has been no medical improvement. (See step (v).)

(iv) If there has been medical improvement, we must determine whether it is related to your ability to do work in accordance with paragraphs (b)(1)(i) through (b)(1)(iv) of this section; i.e., whether or not there has been an increase in the residual functional capacity based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to your ability to work, see step (v). If medical improvement is related to your ability to do work, see step (vi).

(v) If we found at step (iii) that there has been no medical improvement or if we found at step (iv) that the medical improvement is not related to your ability to work, we consider whether any of the exceptions in paragraphs (b)(3) and (b)(4) of this section apply. If none of them apply, your disability will be found to continue. If one of the first group of exceptions to medical improvement applies, see step (vi). If an exception from the second group of exceptions to medical improvement applies, your disability will be found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process.

(vi) If medical improvement is shown to be related to your ability to do work

or if one of the first group of exceptions to medical improvement applies, we will determine whether all your current impairments (in combination) are severe (see §416.921). This determination will consider all your current impairments and the impact of the combination of these impairments on your ability to function. If the residual functional capacity assessment in step (iv) above shows significant limitation of your ability to do basic work activities, see step (vii). When the evidence shows that all your current impairments in combination do not significantly limit your physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature. If so, you will no longer be considered to be disabled.

(vii) If your impairment(s) is severe, we will assess your current ability to engage in substantial gainful activity in accordance with §416.961. That is we will assess your residual functional capacity based on all your current impairments and consider whether you can still do work you have done in the past. If you can do such work, disability will be found to have ended.

(viii) If you are not able to do work you have done in the past, we will consider one final step. Given the residual functional capacity assessment and considering your age, education and past work experience, can you do other work? If you can, disability will be found to have ended. If you cannot, disability will be found to continue.

(6) *The month in which we will find you are no longer disabled.* If the evidence shows that you are no longer disabled, we will find that your disability ended in the following month—

(i) For purposes of §416.1331 (under which benefits can be paid for the month in which disability ends and the two following months) the earliest of the following months—

(A) The month the evidence shows that you are no longer disabled under the rules set out in this section, and you were disabled only for a specified period of time in the past;

(B) The month the evidence shows that you are no longer disabled under the rules set out in this section, but not earlier than the month in which we mail you a notice saying that the

information we have shows that you are not disabled;

(C) The month in which you return to full-time work, with no significant medical restrictions and acknowledge that medical improvement has occurred, and we expected your impairment(s) to improve (see §416.991);

(D) The first month following completion of your trial work period for which it is determined that you have demonstrated the ability to do substantial gainful activity;

(E) The first month in which you fail without good cause to follow prescribed treatment, when the rule set out in paragraph (b)(4)(iv) of this section applies;

(F) The first month in which you were told by your physician that you could return to work provided there is no substantial conflict between your physician's and your statements regarding your awareness of your capacity for work and the earlier date is supported by substantial evidence; or

(G) The first month in which you failed without good cause to do what we asked, when the rule set out in paragraph (b)(4)(ii) of this section applies.

(i) For all other purposes, the month preceding the termination month. The termination month, as that term is used in this paragraph, is the first month after the 15-month reentitlement period (described in §416.992a, in which you engage in or are determined able to engage in substantial gainful activity or, if earlier, the first month after a trial work period in which your impairment is determined, based on medical or other evidence, to no longer exist or not be a disabling impairment as described in §416.911.

(7) *Before we stop your benefits.* If we find you are no longer disabled, before we stop your benefits, we will give you a chance to explain why we should not do so. Subparts M and N of this part describe your rights and the procedures we will follow.

(c) *Persons who were found disabled under a State plan.* If you became entitled to benefits because you were found to be disabled under a State plan, we will first evaluate your impairment(s) under the rules explained in paragraph

(b) of this section. We will apply the same steps as described in paragraph (b) of this section to the last decision granting or affirming entitlement to benefits under the State plan. If we are not able to find that your disability continues on the basis of these rules, we will then evaluate your impairment(s) under the appropriate State plan. If we are not able to find that your disability continues under these State plan criteria, we will find that your disability ends. Disability will be found to end the month the evidence shows that you are no longer disabled under the criteria in paragraph (b) of this section (or appropriate State plan criteria), subject to the rules set out in paragraph (b)(6) of this section.

[50 FR 50137, Dec. 6, 1985; 51 FR 7063, Feb. 28, 1986; 51 FR 16015, Apr. 30, 1986, as amended at 52 FR 44971, Nov. 24, 1987; 56 FR 5562, Feb. 11, 1991; 59 FR 1636, Jan. 12, 1994]

§416.994a How we will determine whether your disability continues or ends, disabled children.

(a) *Evaluation of continuing disability, in general.* There is a statutory requirement that, if you are eligible for disability benefits as a disabled child, your continued eligibility for such benefits must be reviewed periodically. There are a number of factors we consider when we decide whether your disability continues.

(1) If your current impairment(s) does not meet or equal any current listing, we determine whether there has been any medical improvement in your impairment(s) that is "related to the ability to work," i.e., your ability to function independently, appropriately, and effectively in an age-appropriate manner. (We define the term "medical improvement" in paragraph (c). We define the term "related to the ability to work" as it applies to children in paragraph (d).) If there has not been any medical improvement in your impairment(s), or if the medical improvement is not related to the ability to work, we will generally find that your disability continues; there are exceptions to this general rule, which we describe in paragraphs (f) and (g). If there has been medical improvement related to the ability to work, or when certain exceptions apply, we will

determine whether you are currently disabled under the rules in §§416.924 through 416.924e. Even where medical improvement related to your ability to work or an exception applies, in most cases, we will find that your disability has ended only if we also find that you are not currently disabled.

(2) Our determinations and decisions under this section will be made on a neutral basis, without any initial inference as to the presence or absence of disability being drawn from the fact that you have been previously found disabled. We will consider all evidence you submit, as well as all evidence we obtain from your treating physician(s) and other medical and nonmedical sources. What constitutes "evidence" and our procedures for obtaining it are set out in §§416.912 through 416.918. Our determination regarding whether your disability continues will be made on the basis of the weight of the evidence.

(b) *Sequence of evaluation.* To assure that disability reviews are carried out in a uniform manner, that decisions of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally, and are fully documented, we follow specific steps in determining whether your disability continues. If we can make a favorable determination or decision at any point in the sequence, we do not review further. The steps are:

(1) *Do you have an impairment(s) that meets or equals the severity of any impairment listed in appendix 1 of subpart P of part 404 of this chapter?* If you have an impairment that meets a current listing, or an impairment or combination of impairments that is of equivalent severity to a current listing, we will find that your disability continues. For our rules on how we determine whether impairments meet or are equivalent to listings, see §§416.925 and 416.926a.

(2) *Has there been medical improvement in your condition(s)?* If you do not have an impairment(s) that meets or is equivalent to any current listing we will determine whether there has been medical improvement in your impairment(s) since our most recent favorable determination or decision. (The term *medical improvement* is de-

fined in paragraph (c).) If there has been medical improvement, as shown by a decrease in the medical severity of your impairment(s), we will proceed to the next step. If there has been no decrease in the medical severity of your impairment(s), we will find that your disability continues, unless one of the exceptions to medical improvement described in (f) or (g) applies.

(i) If one of the first group of exceptions to medical improvement applies, we will proceed to step 4.

(ii) If one of the second group of exceptions to medical improvement applies, we may find that your disability has ended.

(3) *If there has been medical improvement, is it related to the ability to work?* If there has been medical improvement in your impairment(s), we will determine whether your medical improvement is related to the ability to work, as defined for children in (d). If it is, we will proceed to the next step. If the medical improvement of your impairment(s) is not related to the ability to work, we will find that your disability continues, unless one of the exceptions to medical improvement described in (f) or (g) applies.

(i) If one of the first group of exceptions to medical improvement applies, we will proceed to the next step.

(ii) If one of the second group of exceptions to medical improvement applies, we may find that your disability has ended.

(4) *Do you have a severe impairment or combination of impairments?* If there has been medical improvement in your impairment(s) related to the ability to work, or if one of the first group of exceptions applies, we will determine whether your current impairment(s) is severe, as defined in §416.924(d). If your impairment(s) is not severe, we will find that your disability has ended. If your impairment(s) is severe, we will proceed to the last step.

(5) *Are you currently disabled?* In connection with our determination that there has been medical improvement in your impairment(s) related to the ability to work, or if one of the first group of exceptions applies, and you have a severe impairment or combination of impairments, we will do an individualized functional assessment of the

impact of your impairment(s) on your overall ability to function independently, appropriately, and effectively in an age-appropriate manner. (See §§416.924d and 416.924e.) We will use this individualized functional assessment to decide whether you are currently disabled; that is, whether you have an impairment(s) of comparable severity to an impairment that would prevent an adult from engaging in substantial gainful activity. We will apply the rules and guidelines governing the last step of the childhood sequential evaluation process for initial claims in §§416.924 through 416.924e. If you are currently disabled, your eligibility will continue. If you are not currently disabled, your eligibility for disability benefits will end.

(c) *What we mean by medical improvement.* Medical improvement is any decrease in the medical severity of your impairment(s) which was present at the time of the most recent favorable decision that you were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on changes (improvement) in the symptoms, signs, or laboratory findings associated with your impairment(s).

(1) The most recent favorable decision is the latest final determination or decision involving a consideration of the medical evidence and whether you were disabled or continued to be disabled.

(2) The terms *symptoms, signs, and laboratory findings* are defined in §416.928. For children, our definitions of the terms *symptoms, signs, and laboratory findings* may include any abnormalities of physical and mental functioning that we used in making our most recent favorable decision.

(3) Some impairments are subject to temporary remissions, which can give the appearance of medical improvement when in fact there has been none. If you have the kind of impairment that is subject to temporary remissions, we will be careful to consider the longitudinal history of the impairment, including the occurrence of prior remissions and prospects for future worsenings, when we decide whether there has been medical improvement. Improvements that are only temporary

will not warrant a finding of medical improvement.

(4) If we find that there has been improvement in your symptoms, signs, or laboratory findings, we will find that medical improvement has occurred and proceed to determine whether the medical improvement is related to your ability to work.

(d) *What we mean by medical improvement related to the ability to work.* For a child, we say that medical improvement is related to the ability to work when there has been an increase in the ability to function independently, appropriately, and effectively in an age-appropriate manner. Hence, if your impairment(s) has medically improved as defined in (c), but your ability to function in an age-appropriate manner has not increased, we will find that your medical improvement is not related to your ability to work. A determination that there has been medical improvement related to your ability to work does not necessarily mean that we will find that your disability has ended. We must also show that you are not currently disabled using rules governing severity and the last step of the childhood sequential evaluation process for initial claims in §§416.924 through 416.924e. We determine whether medical improvement is related to the ability to work as follows:

(1) *Previous decision based on a finding that your impairment(s) met or equaled a listing.* (i) We do not consider whether your impairment(s) has medically improved until we have decided that you do not have an impairment(s) that meets or equals a current listing. If our most recent favorable decision was based on a finding that your impairment(s) met or equaled in severity a listing that is in our current Listing of Impairments and your impairment(s) no longer meets or equals that listing, we will find at this step that your medical improvement was related to your ability to work. We will do an individualized functional assessment and proceed to determine whether you are currently disabled or whether one of the exceptions applies, as set forth in paragraph (b)(5) of this section.

(ii) If our most recent favorable decision was based on a finding that your

impairment(s) met or equaled a listing that is no longer in the Listing of Impairments or that has since been revised, we will consider whether your impairment(s) continues to meet or equal that prior listing at this step. If your impairment(s) continues to meet or equal the prior listing, we will find that your disability continues, even though your impairment(s) does not meet or equal any current listing. If your impairment does not meet or equal the prior listing, we will find that your medical improvement was related to your ability to work. We will do an individualized functional assessment and proceed to determine whether you are currently disabled or whether one of the exceptions applies, as set forth in paragraph (b)(5) of this section.

(2) *Previous decision based on an individualized functional assessment.* If our most recent favorable decision was based on an individualized functional assessment, we will do a new individualized functional assessment based on the previously existing impairments. However, the new individualized functional assessment will take into consideration any current medical findings or functional limitations related to the previously existing impairments, and will be based on those functions that are appropriate to your current age.

(i) We will use this assessment to determine whether there has been an increase in your ability to function in an age-appropriate manner since our most recent favorable decision by comparing our current assessment with the assessment we made at the time of the most recent favorable decision.

(ii) We will not generally do a new individualized functional assessment for the time of the most recent favorable decision; we will use the assessment we made at the time of the last decision. However, if the most recent favorable decision was based on an individualized functional assessment and we do not have that assessment (for example, because it is missing from your file), we will have to reconstruct the assessment. We will do this by assuming that you had the maximum functional abilities consistent with a decision of allowance or continuance at the time of the most recent favorable decision.

(iii) If there has been improvement in your age-appropriate functioning, we will find that your medical improvement is related to the ability to work, and proceed to determine whether you are currently disabled or whether one of the exceptions applies, as set forth in paragraph (b)(5) of this section.

(e) *Prior file cannot be located.* If we cannot locate your prior file, we will first determine whether you are currently disabled under the sequence set forth in §416.924. (In this way, we will determine that your benefits continue at the earliest time without reconstructing prior evidence.) If so, your benefits will continue unless one of the second group of exceptions applies (see paragraph (g) of this section). If not, we will determine whether an attempt should be made to reconstruct those portions of the missing file that were relevant to our most recent favorable decision (e.g., school records, medical evidence from treating sources, and the results of consultative examinations). This determination will consider the potential availability of old records in light of their age, whether the source of the evidence is still in operation, and whether reconstruction efforts will yield a complete record of the basis for the most recent favorable decision. If relevant parts of the prior record are not reconstructed, either because we decide not to attempt reconstruction or because our efforts failed, we will not find that you have medically improved. The documentation of your current impairment(s) will provide a basis for any future reviews. If the missing file is later found, it may serve as a basis for reopening any determination or decision under this section, in accordance with §416.1488.

(f) *First group of exceptions to medical improvement.* The law provides certain limited situations when your disability can be found to have ended even though medical improvement has not occurred, if your impairment(s) is no longer of comparable severity to any impairment(s) that would make an adult disabled. These exceptions to medical improvement are intended to provide a way of finding that a person is no longer disabled in those limited situations where, even though there has been no decrease in severity of the

impairment(s), evidence shows that the person should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, we must also show that your impairment(s) is now no longer of comparable severity to any impairment(s) that would disable an adult before we can find you are no longer disabled, taking all your current impairments into account, not just those that existed at the time of our most recent favorable decision. As part of the review process, you will be asked about any medical or vocational therapy you received or are receiving. Your answers and the evidence gathered as a result, as well as all other evidence, will serve as the basis for the finding that an exception applies.

(1) *Substantial evidence shows that you are the beneficiary of advances in medical or vocational therapy or technology (related to your ability to work).* Advances in medical or vocational therapy or technology are improvements in treatment or rehabilitative methods which have reduced the severity of your impairment(s). We will apply this exception when substantial evidence shows that you have been the beneficiary of services which reflect these advances and they have favorably affected the severity of your impairment or your ability to function in an age-appropriate manner. This decision will be based on substantial evidence which includes new medical evidence and a new individualized functional assessment. (See §§416.924d and 416.924e.) This exception does not apply if you are eligible to receive special Supplemental Security Income cash benefits, as explained in §416.261. In many instances, an advanced medical therapy or technology will result in a decrease in severity as shown by symptoms, signs, and laboratory findings which will meet the definition of medical improvement. This exception should, therefore, have limited application.

(2) *Substantial evidence shows that you have undergone vocational therapy (related to your ability to work).* Vocational therapy (related to your ability to work) may include, but is not limited to, education, training, or work experience that improves your ability to meet the vocational requirements of

jobs. This decision will be based on substantial evidence which includes new medical evidence and a new individualized functional assessment. (See §§416.924d and 416.924e.) This exception does not apply if you are eligible to receive special Supplemental Security Income cash benefits, as explained in §416.261. If at the time of our review, you have not completed vocational therapy which could affect the continuance of your disability, we will review your claim upon completion of the therapy.

(3) *Substantial evidence shows that, based on new or improved diagnostic or evaluative techniques, your impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.* Changing methodologies and advances in medical and other diagnostic or evaluative techniques have given rise to, and will continue to give rise to, improved methods for determining the causes of (i.e., diagnosing) and measuring and documenting the effects of various impairments on children and their functioning. Where, by such new or improved methods, substantial evidence shows that your impairment(s) is not as severe as was determined at the time of our most recent favorable decision, such evidence may serve as a basis for a finding that you are no longer disabled, provided that you do not currently have an impairment(s) that is of comparable severity to an impairment(s) that would disable an adult. In order to be used under this exception, however, the new or improved techniques must have become generally available after the date of our most recent favorable decision.

(i) *How we will determine which methods are new or improved techniques and when they become generally available.* New or improved diagnostic techniques or evaluations will come to our attention by several methods. In reviewing cases, we often become aware of new techniques when their results are presented as evidence. Such techniques and evaluations are also discussed and acknowledged in medical literature by medical professional groups and other governmental entities. Through these sources, we develop listings of new techniques and when they become generally available. For example, we will

consult the Health Care Financing Administration for its experience regarding when a technique is recognized for payment under Medicare and when they began paying for the technique.

(ii) *How you will know which methods are new or improved techniques and when they become generally available.* We will let you know which methods we consider to be new or improved techniques and when they become available through two vehicles.

(A) Some of the future changes in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter will be based on new or improved diagnostic or evaluative techniques. Such listings changes will clearly state this fact as they are published as Notices of Proposed Rulemaking and the new or improved technique will be considered generally available as of the date of the final publication of that particular listing in the FEDERAL REGISTER.

(B) From time to time, we will publish in the FEDERAL REGISTER cumulative lists of new or approved diagnostic techniques or evaluations that have been in use since 1970, how they changed the evaluation of the applicable impairment and the month and year they became generally available. We will include any changes in the Listing of Impairments published in the Code of Federal Regulations since 1970 that are reflective of new or improved techniques. We will not process any cases under this exception using a new or improved diagnostic technique that we have not included in a published notice until we have published an updated cumulative list. The period between publications will be determined by the volume of changes needed.

(4) *Substantial evidence demonstrates that any prior disability decision was in error.* We will apply the exception to medical improvement based on error if substantial evidence (which may be evidence on the record at the time any prior determination or decision of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination or decision) demonstrates that a prior determination or decision (of allowance or continuance) was in

error. A prior determination or decision will be found in error only if:

(i) Substantial evidence shows on its face that the determination or decision in question should not have been made (e.g., the evidence in your file, such as pulmonary function study values, was misread, or an adjudicative standard, such as a listing in appendix 1 of subpart P of part 404 of this chapter, was misapplied).

(ii) At the time of the prior evaluation, required and material evidence of the severity of your impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that, had such evidence been present at the time of the prior determination or decision, disability would not have been found.

(iii) New substantial evidence that relates to the prior determination or decision refutes the conclusions that were based upon the prior evidence at the time of that determination or decision (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that, had the new evidence (which relates to the prior determination or decision) been considered at the time of the prior determination or decision, the claim would not have been allowed or continued. A substitution of current judgment for that used in the prior favorable determination or decision will not be the basis for applying this exception.

(iv) The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision (see §§416.1488 and 416.1489) are met.

(g) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination or decision that you are no longer disabled. In these situations, the determination or decision will be made without a finding that you have demonstrated medical improvement related to the ability to work or that you are currently not disabled under the rules in §§416.924 through 416.924e. There is no set point in the continuing disability review sequence described in paragraph (b) of this section at which we must consider

these exceptions; exceptions in the second group may be considered at any point in the process.

(1) *A prior determination or decision was fraudulently obtained.* If we find that any prior favorable determination or decision was obtained by fraud, we may find that you are not disabled. In addition, we may reopen your claim under the rules in §416.1488. In determining whether a prior favorable determination or decision was fraudulently obtained, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have had at the time.

(2) *You do not cooperate with us.* If there is a question about whether you continue to be disabled and we ask you to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 416.1411 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, §416.918 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability ends will be the first month in which you failed to do what we asked.

(3) *We are unable to find you.* If there is a question about whether you continue to be disabled and we are unable to find you to resolve the question, we will suspend your payments. The month your payments are suspended will be the first month in which the question arose and we could not find you.

(4) *You fail to follow prescribed treatment which would be expected to restore your ability to function independently, appropriately, and effectively in an age-appropriate manner.* If treatment has been prescribed for you which would be expected to restore your ability to function independently, appropriately, and effectively in an age-appropriate manner, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have good cause for failing to follow that treatment, we

will find that your disability has ended (see §416.930(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

(h) *The month in which we will find you are no longer disabled.* If the evidence shows that you are no longer disabled, we will find that your disability ended in the following month—

(1) The month the evidence shows that you are no longer disabled under the rules set out in this section, and you were disabled only for a specified period of time in the past;

(2) The month the evidence shows that you are no longer disabled under the rules set out in this section, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not disabled;

(3) The month in which you return to, or begin, full-time work with no significant medical restrictions, and acknowledge that medical improvement has occurred, and we expected your impairment(s) to improve (see §416.991);

(4) The first month in which you fail without good cause to follow prescribed treatment, when the rule set out in paragraph (g)(4) of this section applies;

(5) The first month in which you were told by your physician that you could return to age-appropriate activities, provided there is no substantial conflict between your physician's and your statements regarding your awareness of your capacity, and the earlier date is supported by substantial evidence; or

(6) The first month in which you failed without good cause to do what we asked, when the rule set out in paragraph (g)(2) of this section applies.

(i) *Before we stop your benefits.* If we find you are no longer disabled, before we stop your benefits, we will give you a chance to explain why we should not do so. Subparts M and N of this part describe your rights and the procedures we will follow.

[56 FR 5562, Feb. 11, 1991; 56 FR 13266, 13365, Apr. 1, 1991, as amended at 58 FR 47586, Sept. 9, 1993; 59 FR 1637, Jan. 12, 1994]

§416.995 If we make a determination that your physical or mental impairment(s) has ceased, did not exist or is no longer disabling (Medical Cessation Determination).

If we make a determination that the physical or mental impairment(s) on the basis of which disability or blindness benefits were payable has ceased, did not exist or is no longer disabling (a medical cessation determination), your benefits will stop. You will receive a written notice explaining this determination and the month your benefits will stop. The written notice will also explain your right to appeal if you disagree with our determination and your right to request that your disability or blindness benefits be continued under §416.996. The continued benefit provisions of this section do not apply to an initial determination on an application for disability or blindness benefits or to a determination that you were disabled or blind only for a specified period of time.

[53 FR 29023, Aug. 2, 1988]

§416.996 Continued disability or blindness benefits pending appeal of a medical cessation determination.

(a) *General.* If we determine that you are not eligible for disability or blindness benefits because the physical or mental impairment(s) on the basis of which such benefits were payable is found to have ceased, not to have existed, or to no longer be disabling, and you appeal that determination, you may choose to have your disability or blindness benefits, including special cash benefits or special SSI eligibility status under §§416.261 and 416.264, continued pending reconsideration and/or a hearing before an administrative law judge on the disability/blindness cessation determination. If you appeal a medical cessation under both title II and title XVI (a concurrent case), the title II claim will be handled in accordance with title II regulations while the title XVI claim will be handled in accordance with the title XVI regulations.

(1) Benefits may be continued under this section only if the determination that your physical or mental impairment(s) has ceased, has never

existed, or is no longer disabling is made after October 1984.

(2) Continued benefits under this section will stop effective with the earlier of: (i) The month before the month in which an administrative law judge's hearing decision finds that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling or the month before the month of a new administrative law judge decision (or final action is taken by the Appeals Council on the administrative law judge's recommended decision) if your case was sent back to an administrative law judge for further action; or (ii) the month before the month in which no timely request for reconsideration or administrative law judge hearing is pending after notification of our initial or reconsideration cessation determination. These benefits may be stopped or adjusted because of certain events (such as, change in income or resources or your living arrangements) which may occur while you are receiving these continued benefits, in accordance with §416.1336(b).

(b) *Statement of choice.* If you or another party (see §416.1432(a)) request reconsideration under §416.1409 or a hearing before an administrative law judge in accordance with §416.1433 on our determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling, or if your case is sent back (remanded) to an administrative law judge for further action, we will explain your right to receive continued benefits and ask you to complete a statement indicating that you wish to have benefits continued pending the outcome of the reconsideration or administrative law judge hearing. If you request reconsideration and/or hearing but you do not want to receive continued benefits, we will ask you to complete a statement declining continued benefits indicating that you do not want to have your benefits continued during the appeal. A separate election must be made at each level of appeal.

(c) *What you must do to receive continued benefits pending notice of our reconsideration determination.* (1) If you want to receive continued benefits pending the outcome of your request for reconsideration, you must request

reconsideration and continuation of benefits no later than 10 days after the date you receive the notice of our initial determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling. Reconsideration must be requested as provided in §416.1409, and you must request continued benefits using a statement in accordance with paragraph (b) of this section.

(2) If you fail to request reconsideration and continued benefits within the 10-day period required by paragraph (c)(1) of this section, but later ask that we continue your benefits pending a reconsidered determination, we will use the rules in §416.1411 to determine whether good cause exists for your failing to request benefit continuation within 10 days after receipt of the notice of the initial cessation determination. If you request continued benefits after the 10-day period, we will consider the request to be timely and will pay continued benefits only if good cause for delay is established.

(d) *What you must do to receive continued benefits pending an administrative law judge's decision.* (1) To receive continued benefits pending an administrative law judge's decision on our reconsideration determination, you must request a hearing and continuation of benefits no later than 10 days after the date you receive the notice of our reconsideration determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling. A hearing must be requested as provided in §416.1433, and you must request continued benefits using a statement in accordance with paragraph (b) of this section.

(2) If you fail to request a hearing and continued benefits within the 10-day period required under paragraph (d)(1) of this section, but you later ask that we continue your benefits pending an administrative law judge's decision, we will use the rules as provided in §416.1411 to determine whether good cause exists for your failing to request benefit continuation within 10 days after receipt of the reconsideration determination. If you request continued benefits after the 10-day period, we will consider the delayed request to be timely and will pay continued benefits

only if good cause for delay is established.

(e) *What you must do when your case is remanded to an administrative law judge.* If we send back (remand) your case to an administrative law judge for further action under the rules provided in §416.1477, and the administrative law judge's decision or dismissal order issued on your medical cessation appeal is vacated and is no longer in effect, you may be eligible for continued benefits pending a new decision by the administrative law judge or final action by the Appeals Council on the administrative law judge's recommended decision.

(1) When your case is remanded to an administrative law judge, and you have elected to receive continued benefits, we will contact you to update our file to verify that you continue to meet the nonmedical requirements to receive benefits based on disability or blindness. To determine your correct payment amount, we will ask you to provide information about events such as changes in living arrangements, income, or resources since our last contact with you. If you have returned to work, we will request additional information about this work activity. Unless your earnings cause your income to be too much to receive benefits, your continued benefits will be paid while your appeal of the medical cessation of your disability/blindness is still pending, unless you have completed a trial work period and are engaging in substantial gainful activity. If you have completed a trial work period and previously received continued benefits you may still be eligible for special cash benefits under §416.261 or special SSI eligibility status under §416.264. (Effective July 1, 1987, a title XVI individual is no longer subject to a trial work period or cessation based on engaging in substantial gainful activity in order to be eligible for special benefits under §416.261 or special status under §416.264.) If we determine that you no longer meet a requirement to receive benefits, we will send you a written notice. The written notice will explain why your continued benefits will not be reinstated or will be for an amount less than you received before the prior administrative law judge's

decision. The notice will also explain your right to reconsideration under §416.1407, if you disagree. If you request a reconsideration, you will have the chance to explain why you believe your benefits should be reinstated or should be at a higher amount. If the final decision on your appeal of your medical cessation is a favorable one, we will send you a written notice in which we will advise you of any right to re-entitlement to benefits including special benefits under §416.261 or special status under §416.264. If you disagree with our determination on your appeal, you will have the right to appeal this decision.

(2) After we verify that you meet all the nonmedical requirements to receive benefits as stated in paragraph (e)(1) of this section, and if you previously elected to receive continued benefits pending the administrative law judge's decision, we will start continued benefits again. We will send you a notice telling you this. You do not have to complete a request to have these same benefits continued through the month before the month the new decision or order of dismissal is issued by the administrative law judge or through the month before the month the Appeals Council takes final action on the administrative law judge's recommended decision. These continued benefits will begin again with the first month of nonpayment based on the prior administrative law judge hearing decision or dismissal order. Our notice explaining continued benefits will also tell you to report to us any changes or events that affect your receipt of benefits.

(3) When your case is remanded to an administrative law judge, and if you did not previously elect to have benefits continued pending an administrative law judge decision, we will send you a notice telling you that if you want to change that election, you must request to do so no later than 10 days after you receive our notice. If you do make this new election, and after we verify that you meet all the nonmedical requirements as explained in paragraph (e)(1) of this section, benefits will begin with the month of the Appeals Council remand order and will

continue as stated in paragraph (e)(2) of this section.

(4) If a court orders that your case be sent back to us (remanded) and your case is sent to an administrative law judge for further action under the rules provided in §416.1483, the administrative law judge's decision or dismissal order on your medical cessation appeal is vacated and is no longer in effect. You may be eligible for continued benefits pending a new decision by the administrative law judge or final action by the Appeals Council on the administrative law judge's recommended decision. In these court-remanded cases reaching the administrative law judge, we will follow the same rules provided in paragraph (e) (1), (2), and (3) of this section.

(f) *What if your benefits are suspended, reduced or terminated for other reasons.* If we determine that your payments should be reduced, suspended or terminated for reasons not connected with your medical condition (see subpart M of Regulations No. 16) benefits may be continued under the procedure described in §416.1336.

(g) *Responsibility to pay back continued benefits.* (1) If the final decision of the Secretary affirms the determination that you are not entitled to benefits, you will be asked to pay back any continued benefits you receive. However, you will have the right to ask that you not be required to pay back the benefits as described in the overpayment recovery and waiver provisions of subpart E of this part.

(2) Waiver of recovery of an overpayment resulting from continued benefits to you may be considered as long as the cessation determination was appealed in good faith. We will assume that your appeal was made in good faith and, therefore, you have the right to waiver consideration *unless* you fail to cooperate in connection with the appeal, e.g., if you fail (without good reason) to give us medical or other evidence we request, or to go for a physical or mental examination when requested, in connection with the appeal. In determining whether you have good cause for failure to cooperate and, thus, whether an appeal was made in good faith, we will take into account any physical, mental, educational, or

linguistic limitations (including any lack of facility with the English language) you may have which may have caused your failure to cooperate.

[53 FR 29023, Aug. 2, 1988; 53 FR 39015, Oct. 4, 1988, as amended at 59 FR 1637, Jan. 12, 1994]

§ 416.998 If you become disabled by another impairment(s).

If a new severe impairment(s) begins in or before the month in which your last impairment(s) ends, we will find that your disability is continuing. The new impairment(s) need not be expected to last 12 months or to result in death, but it must be severe enough to keep you from doing substantial gainful activity, or severe enough so that you are still disabled under §416.994.

[50 FR 60147, Dec. 6, 1985; 51 FR 16015, Apr. 30, 1986]

Subpart J—Determinations of Disability

AUTHORITY: Secs. 702(a)(5), 1614, 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1382c, 1383, and 1383b).

SOURCE: 46 FR 29211, May 29, 1981, unless otherwise noted.

GENERAL PROVISIONS

§ 416.1001 Purpose and scope.

This subpart describes the standards of performance and administrative requirements and procedures for States making determinations of disability for the Secretary under title XVI of the Act. It also establishes the Secretary's responsibilities in carrying out the disability determination function.

(a) Sections 416.1001 through 416.1003 describe the purpose of the regulations and the meaning of terms frequently used in the regulations. They also briefly set forth the responsibilities of the Secretary and the States covered in detail in other sections.

(b) Sections 416.1010 through 416.1018 describe the Secretary's and the State's responsibilities in performing the disability determination function.

(c) Sections 416.1020 through 416.1033 describe the administrative responsibilities and requirements of the States. The corresponding role of the Secretary is also set out.

(d) Sections 416.1040 through 416.1050 describe the performance accuracy and processing time standards for measuring State agency performance.

(e) Sections 416.1060 through 416.1061 describe when and what kind of assistance the Secretary will provide State agencies to help them improve performance.

(f) Sections 416.1070 through 416.1075 describe the level of performance below which the Secretary will consider a State agency to be substantially failing to make disability determinations consistent with the regulations and other written guidelines and the resulting action the Secretary will take.

(g) Sections 416.1080 through 416.1083 describe the rules for resolving disputes concerning fiscal issues and providing hearings when we propose to find that a State is in substantial failure.

(h) Sections 416.1090 through 416.1094 describe when and what action the Secretary will take and what action the State will be expected to take if the Secretary assumes the disability determination function from a State agency.

§ 416.1002 Definitions.

For purposes of this subpart:

Act means the Social Security Act, as amended.

Class or classes of cases means the categories into which disability claims are divided according to their characteristics.

Determination of disability or disability determination means one or more of the following decisions:

(a) Whether or not a person is under a disability;

(b) The date a person's disability began; or

(c) The date a person's disability ended.

Disability means *disability* or *blindness* as defined in sections 1614(a)(2) and (3) of the Act.

Disability determination function means making determinations as to disability or blindness and carrying out related administrative and other responsibilities.

Disability program means the Federal program for providing supplemental security income benefits for the blind

COMPARISON OF OPTIONS FOR DETERMINING SSI CHILDHOOD DISABILITY UNDER WELFARE REFORM

	SEVERITY STANDARD FOR DISABILITY	REDUCTIONS IN NUMBER OF CHILDREN RECEIVING SSI PAYMENTS		SSI AND MEDICAID COSTS FROM 1997-2002	EFFECT OF OPTIONS ON OUTLAYS IN 2002	
		CURRENT RECIPIENTS REMOVED FROM ROLLS BY SEPTEMBER 1997 (down from 1.0 million before welfare reform)	IN 2002 (down from 1.3 million before welfare reform)		Additional Eligible Children	Additional SSI and Medicaid Costs
Option 1	Significantly Tighten Eligibility	190,000	250,000	0	0	0
Option 2	Tighten Eligibility; Modify Determination Process	145,000	185,000	\$2.0 billion	65,000	\$0.5 billion
Option 3	Add New Step with Lower Standard than Options 1 or 2	45,000	50,000	\$6.6 billion	200,000	\$1.5 billion
Option 4	Same as Option 2, but Slow Phase-in of Current Recipients	0	175,000	\$3.9 billion	75,000	\$0.6 billion
Option 4A	Same as Option 2, but "Grandfather" Current Recipients	0	110,000	\$5.8 billion	140,000	\$0.8 billion