Questions Concerning a Voucher Program for Disabled Children

1. How would State supplements be treated under a voucher program? Would States have the option of paying cash or giving vouchers; even if SSA administers supplements?

2. What items and services might vouchers cover, and would different diagnostic categories be eligible for different items and services?

3. Who would determine voucher needs of each child?

4. Would the cost of a service that is reimbursed by voucher also be allowed to be tax-deductible?

5. In administering a voucher program, how could we be sure that an item the voucher was issued for was not covered by Medicaid or also was, or should have been, paid by Medicaid?

6. The goods and services covered by Medicaid vary from State to State. Therefore, would it be more appropriate for a voucher program to be handled on the State level rather than by the cash benefit program?

7. If the vouchers were limited in value to the amount of the SSI benefit level, would we permit families to save vouchers in order to purchase major items (e.g., a modified car or van or dwelling modifications)? Would we allow vouchers to be saved on a long-term basis as a hedge against parents' old age?

8. Could we issue 6 months' or a year's worth of vouchers at a time if the need was for a large purchase?

9. Would a child eligible for vouchers be eligible for AFDC, if family qualified, to meet nonmedical needs? If so, should we eliminate the "general costs" category? Note that in California Food Stamps is now cashed out and added to the SSI supplement.

10. Unlike the food stamp program which is a single-purpose program, vouchers for children could address many needs. Does this mitigate against a paper voucher and toward a debit account process?

11. Would the voucher system be implemented nationwide or would we start with several States to refine the system?

12. Would there be a list of generally reimbursable items and a second category where special permission would be needed? For example, under certain circumstances, could a family purchase a car or a van?

13. If the system was run on the basis of a debit account system, would providers of all services on "the list" be given special access numbers to debit the account?

14. Instead of vouchers, should SSI be part of a larger block grant administered by the States? If this is done, what guarantees would the Federal government have that disabled children received appropriate services and support?

15. Would the voucher be set at the current SSI level per child and any unused amounts revert to Treasury? Under this scheme, would AFDC concurrent eligibility be allowed?

16. Would the entire voucher program be administered by the Federal Government or the State governments? The Social Security Administration is not experienced in delivering social services. SSA determines eligibility.

17. Would one way to administer a voucher system be to require each child to have an individual development plan to get voucher eligibility?

18. Should we establish eligibility solely for Medicaid without any need of AFDC or SSI participation?

19. What are the administrative costs? Who would pay for administration?

20. How would overpayments be handled? Should voucher amounts be determined differently from how cash benefit amounts are determined so that vouchers would not be regarded as overpayments?

21. Retroactive payments due for the period while disability decision/appeal is pending-- would vouchers be issued for retroactive period? If so, would there be limits, such as expenses incurred/unmet needs during that period?

22. If an SSI minor child is in the care and custody of an SSI-eligible parent, what is the rationale for vouchers for the child and cash benefits for the parent?

DISABILITY DIGEST

Social Security Administration

Office of Disability

Code:
Date:
Number: 92-1

INTRODUCTION

The purpose of the Disability Digest is to promote consistent national application of the disability program. It will provide discussion and resolution of questions addressing various program and procedural issues arising from information contained in the Program Operations Manual System (POMS), Part IV, Disability Insurance (DI). The Digest will be used as a companion to the POMS process to evaluate and adjudicate disability cases in concert with existing POMS guidelines. The Digest may be used to support POMS instructions or Listings, which are the basis for the issuances; but, any statement or implication that the Digest item itself is the authority for case action must be avoided. The discussion may arise out of case situations or suggestions submitted by users. Each Digest item will be used to discuss general and specific disability issues, and to explain or clarify these in light of the aforementioned existing program and procedural guidelines.

The Digest will not be used to implement new policy or procedures, or to supersede or supplant existing POMS instructions. Discussions in the Digest are intended to provide perspective rather than to mandate action. Adjudicators will consider all case facts, including but not limited to, the issue discussed in the Digest. The value and usefulness of the Digest flows from its emphasis on brief, direct responses to single issues.

To facilitate easy reference, all Digest items will be coded using POMS and/or Listing of Impairment numbering systems. These systems constitute a framework for guidance that all POMS users are familiar with; and, all issuances should fit into one or both numbering systems. Digest items can be interfiled in the appropriate POMS chapters, or according to the POMS or Listing numbers in a separate binder. References (and cross-references when applicable) will be listed on all Digest items. Necessary notations should be made on the POMS table of contents to assist in locating the information.

DISABILITY DIGEST

Social Security Administration

Office of Disability

Code: Listing 2.09
Date:
Number: 92-3

Notice: All information presented in this issuance is instructive, clarifying or administrative in nature and does not represent new substantive rules that could reasonably be expected to have an impact on entitlement determinations.

Title: Medical Equivalence to Listing 2.09

Reference: Listing of Impairments 2.00B3 and 2.09; and POMS DI 24505.015C2

Issue:

How Should Lack of Intelligible Speech Because of Hearing Impairment be Adjudicated:

Discussion:

When organic loss of speech results in inability to produce by any means speech which can be heard, understood, and sustained, the claimant meets Listing of Impairments 2.09. Paragraph 2.00B3 which defines organic loss of speech limits the application of the "meets concept" under Listing 2.09 to anatomical abnormality of the larynx but does not limit the application of equivalency. However, when a hearing impairment is the cause of the inability to produce ..., the claimant should be considered to medically equal Listing 2.09. Program Operations Manual System DI 24505.015C2, which addresses the application of the equivalence concept when an impairment is not listed, is appropriately applied when 1/there is a medically documented hearing loss, 2/the hearing loss is not of listing level severity, 3/there is a medically observed/documented speech impairment, and 4/communication is accomplished primarily through the use of sign language.

Application of the equivalence concept, when unintelligible speech or total dependence on sign language because of a hearing impairment is documented in claims folders, is encouraged as a practical program procedure. The evaluation of claims of severely hearing impaired individuals may be greatly simplified and expensive audiometric testing may be avoided through treatment source documentation of the claimant's communication ability. It is also important to remember that individuals who develop profound hearing impairments prior to the development of speech and language skills (approximately age 3) will usually not develop effective verbal communication ability.

DISABILITY DIGEST

Social Security Administration

Office of Disability

Code : DI 24580.001
Date :
Number: 92-4

Notice: **All information presented in this issuance is instructive, clarifying or administrative in nature and does not represent new substantive rules that could reasonably be expected to have an impact on entitlement determinations.**

Title: Definition of Treating Source

Reference: DI 22505.001C, DI 22510.010B.1, DI 24515.003, DI 24515.005, DI 24580.001B.1, SSR 87-6

Issue: Is the definition of "treating source" for purposes of selecting a CE source and for evaluating medical opinions different from that of "treatment source" for purposes of evaluating epilepsy?

Discussion: Yes. We have defined a treating source for purposes of selecting a CE source and for evaluating medical opinions to be the claimant's own physician (or psychologist or other acceptable medical source). Under this definition, a health care facility, such as a hospital, clinic, or HMO, cannot be a treating source because a treating source must be an individual with whom the claimant has an ongoing treatment relationship. Since the individual's physician is usually most knowledgeable about the claimant, he or she is usually in the best position to give us a medical opinion about the claimant's functional abilities despite the impairment(s) and is the preferred source for a CE.

There are explicit definitions of treating source, source of record, and medical source now included in the POMS as a result of the publication of the CE/MER regulations. The broader term "medical source" is defined in the regulations and POMS to include a treating source and source of record, such as a health care facility.

These new definitions have raised a question about the previously defined term "treatment source" for purposes of evaluating epilepsy and its treatment. In this context, the intent of our policy is that there be a constant "medical source" to prescribe and monitor the claimant's treatment. This source may be a health care facility that the claimant regularly visits, even though the claimant does not see the same physician on each visit. Here, the ongoing treatment relationship can be with the

facility itself, rather than with an individual physician in that facility.

The reason for this policy is that the important factors in evaluating epilepsy are the treatment regimen prescribed for control of seizures and the claimant's response to that treatment, not the particular physician who originally prescribed the treatment or the various physicians who have followed the claimant's response to treatment. The longitudinal clinical record about these two factors maintained by a health care facility will satisfy our policy requirements for accurately evaluating epilepsy and its treatment regimen for disability program purposes.

In connection with work now underway to revise the neurological listings, we will change the cited references about epilepsy to refer more accurately to treatment provided by a "medical source," rather than a "treatment source."

DISABILITY DIGEST

Social Security Administration

Office of Disability

Code: DI 25215
Date: August 1992
Number: 92-5

Notice: All information presented in this issuance is instructive, clarifying or administrative in nature and does not represent new substantive rules that could reasonably be expected to have an impact on entitlement determinations.

Title: Medical Issues--Apnea

Reference: 416.924d(e), DI 25220.015H

Issue: Determining severity of a child's impairment when sleep apnea monitors are used.

Discussion:

Questions: Do ongoing episodes of apnea in a child who uses a sleep apnea monitor represent a severe impairment? To what extent should a family history of Sudden Infant Death Syndrome (SIDS) be considered?

Response: Apnea during infancy, without other underlying organic factors, usually does not persist beyond 6 months of age. Apnea should be considered a severe impairment when associated with repeated episodes of cyanosis, or in the event that cardiopulmonary resuscitation has been required. Infants with associated, metabolic disorders, cardiac or vascular anomalies, and arrhythmias should be evaluated according to the appropriate body system.

A family history of siblings who died of SIDS may be a clinical factor in the decision to recommend use of an apnea monitor in an infant with or without actual apneic episodes, but it does not of itself indicate the existence of a severe impairment. Impairment severity should be determined primarily on the clinical manifestations of apnea in the particular claimant. These clinical manifestations include frequency, duration, and the need for resuscitation. Other factors in the determination of severity are discussed in Program Operations Manual System (POMS) DI 25215.005.

If a severe impairment is found is exist, but the claimant neither meets nor medically or functionally equals a listed impairment, an individualized functional assessment is necessary to assess the

impact of the impairment on the domains. POMS DI 25220.015H discusses how assistive devices or adaptations are to be considered when evaluating a child's overall ability to function independently, appropriately, and effectively in an age-appropriate manner.

DISABILITY DIGEST

Social Security Administration

Office of Disability

Code: Listings 110.06/110.07
Date: August 1992
Number: 92-7

Notice: All information presented in this issuance is instructive, clarifying or administrative in nature and does not represent new substantive rules that could reasonably be expected to have an impact on entitlement determinations.

Title: Multiple Body System--Down Syndrome

Reference: Listings 110.06/110.07, POMS DI 24575.901

Issue: Determining presence of non-mosaic Down syndrome on the basis of clinical findings and other medical evidence absent a specific statement to the contrary.

Discussion:

In Question and Answer Format

Question: If the clinical findings and other medical evidence are consistent with non-mosaic Down syndrome (DS), can mosaic DS be ruled out for adjudicative purposes in the absence of a specific statement or report to the contrary?

Response: Yes. In DS the differential diagnosis is as important as the documentation and evaluation requirements for determining disability depending on which listing is used. Listing 110.06 is predicated on our adjudicative experience which has shown that virtually all infants who have non-mosaic DS will be found disabled when the effects of the impairment are properly documented and evaluated. Under this listing disability is established from birth where the diagnosis of non-mosaic DS is established by clinical and laboratory findings. In contrast, Listing 110.07, under which the mosaic form of DS is evaluated, carries no such presumption. Under this listing, in addition to the clinical description and definitive laboratory tests, the listing requires documentation of the effects of the impairment on one or more body systems. The listing may or may not be met depending on the level of severity of the impairment. In those cases where the listing is not met, adjudication would continue through the remaining steps of the sequential evaluation process for children.

The mosaic form of DS is far less common than the non-mosaic form, occurring with only a 1 to 2.4 percent relative frequency in the population of children with confirmed DS. Our experience shows that laboratories identify mosaic DS when the karyotyped cells show some normal and some abnormal chromosomes, but are less likely to further identify trisomy 21 or translocation DS, both terms indicative of non-mosaic DS, as the non-mosaic form of this condition.

In the absence of a specific statement to the contrary, a valid assumption can be made when cytogenic studies are in file that the non-mosaic form of DS is present and 100 percent of the cells studied show the chromosomal abnormality. This assumption can be made even when only a small number of cells are karyotyped as long as all the cells examined show the chromosomal abnormality. Where the actual cytogenic report cannot be obtained, if the medical source statements are adequate to establish that cytogenic studies to confirm the diagnosis of DS were performed, the assumption that the DS is the non-mosaic form also can be reasonably made.

DISABILITY DIGEST

Social Security Administration
Office of Disability

Code: POMS DI 25215.015B
Date: 9/92
Number: 92-8

Notice: All information presented in this issuance is instructive, clarifying, or administrative in nature and does not represent new substantive rules that could reasonably be expected to have an impact on entitlement determinations.

Title: Childhood Disability--Hydrocephalus and Functional Equivalence

Reference: POMS DI 25215.015B, Example 13

Issue: The applicability of functional equals Example 13 to hydrocephalus cases where shunt surgery has been performed.

Discussion:

Question: Does hydrocephalus requiring a shunt meet the criteria for functional equivalence Example Number 13--"Major congenital organ dysfunction...which could be expected to result in death within the first year of life without surgical correction, until 1 year of age."

Response: Ordinarily, hydrocephalus with a shunt would not be found functionally equivalent under Example 13. This example is intended for cases in which a congenital organ defect is so serious that:

- it would be expected to result in death within the first year of life without surgery, and
- there is a reasonable expectation, given the impairment and the surgery required, that the child will continue to be disabled following surgery at least until age 1.

The first of these criteria will often not be met - acute hydrocephalus, even the obstructive form, is not necessarily considered life threatening, requiring the shunting procedure to prevent death within the first 12 months of life. Prior to the

development of shunting procedures, many of these children lived for extended periods of time and certainly past the first year of life.

Even if a particularly severe hydrocephalus might be considered life-threatening within the first year of life, however, the second criterion will ordinarily not be met. The insertion of a shunting device, especially for the obstructive form of hydrocephalus, usually alleviates the acute problem and for the most part the chronic problems. Thus, continued disability up to age 1 would not be expected.

For these reasons, a finding of equivalence using Example 13 would generally be inappropriate.

Of course, a child whose impairment does not meet or equal the listings may still be found disabled following an individualized functional assessment (IFA). Hydrocephalus generally does not meet the strong expectations of disabling impacts required by Example 13, but obviously there may be cases in which hydrocephalus and shunting result in unexpected complications, infections, and relatively long-lasting or chronic problems. In such a case, the IFA may well show that the impairment causes a substantial reduction in the child's ability to function in an age-appropriate manner, and is therefore disabling.

DISABILITY DIGEST

Social Security Administration

Office of Disability

Code : DI
Date : December 1992
Number: 92-12

Notice: All information presented in this issuance is instructive, clarifying or administrative in nature and does not represent new substantive rules that could reasonably be expected to have an impact on entitlement determinations.

Title: Evaluation of Bronchial Asthma

Reference: Listing of Impairments, 3.00C and 3.03B.

Issue: Can an individual equal Listing 3.03B when treatments for acute asthma attacks are administered in a physician's office, rather than in a hospital emergency room?

Discussion:

Most severe asthma attacks are treated by hospitalization or in an emergency room, and more often than not, severe attacks require intravenous therapy. However, hospitalization and/or emergency room therapy of acute asthma attacks is not crucial for a respiratory impairment to equal Listing 3.03B, if documentation per 3.00C is otherwise complete and unequivocal.

In some circumstances, hospital and emergency facilities may not be readily available. In other instances, asthma attacks can worsen dramatically in a physician's office. Therefore, if acute asthma attacks are treated in a physician's office, the facts of the particular case should be reviewed to determine if the findings are equivalent to those in Listing 3.03B.

Social Security Administration

DISABILITY DIGEST

Office of Disability

Code: DI 24501.020
Date: March 1993
Number: 93-3

Notice: All information presented in this issuance is instructive, clarifying or administrative in nature and does not represent new substantive rules that could reasonably be expected to have an impact on entitlement determinations.

Title: Medical Issues--Academic Underachievement

Reference: 416.908, DI 24501.020

Issue: Is academic underachievement a medically determinable impairment?

Discussion:

Questions: Can a child with a normal IQ and no other physical/mental abnormality, who has normal activities of daily living and socialization skills, but who is demonstrating academic underachievement be found to have a medically determinable impairment? If so, what body system, listing, or domains should be used to evaluate academic underachievement?

Response: To respond to these questions, we must define the difference between learning disorders and academic underachievement. Learning disorders are a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition-Revised). They are classified as Specific Developmental Disorders and characterized as "inadequate development of specific academic. . . skills. . . that are not due to demonstrable physical or neurologic disorders, a Pervasive Developmental Disorder, Mental Retardation, or deficient educational opportunities." Learning disorders are medically determinable impairments. Therefore, academic deficits due to learning disorders are impairment-related limitations that should be assessed in whatever domain(s) is appropriate (e.g., cognition; concentration, persistence, and pace).

The term "academic underachievement" should be used for academic deficits not resulting from learning disorders or other medically determinable conditions. These deficits may be the result of a non-impairment-related factor, such as truancy, or apathy regarding educational attainment.

A child who is demonstrating only academic underachievement, as defined above, would not be considered to have a medically determinable impairment. Thus, the question of what body system, listing, or domains to use in the evaluation of academic underachievement is moot.

DISABILITY DIGEST

Social Security Administration

Office of Disability

Code: DI 24515.002
Date: May 1993
Number: 93-7

Notice: All information presented in this issuance is instructive, clarifying or administrative in nature and **does not represent new substantive rules that could** reasonably be expected to have an impact on entitlement determinations.

Title: Medical Issue--High Blood Lead Levels

Reference: DI 24515.002, DI 22510.005

Issue: Adjudication of Childhood Claims Where There is an Indication of High Blood Lead Levels

Discussion:

Question: What is considered a significantly elevated blood lead level?

Answer: As clinical intervention is generally initiated when the blood lead level is at least 10 micrograms/deciliter (ug/dL), this level can be used to indicate a significantly elevated blood lead level. It should be noted, however, that adverse effects can occur at lower levels.

Question: Does this lead level have to remain persistently high over a certain time period?

Answer: No. The existence of a medically determinable impairment is established once the child has been identified as having a high blood lead level and has demonstrated signs or symptoms attributable to the elevated blood lead level. However, since the effects of lead toxicity vary from child to child, the blood lead level, in and of itself, is not determinative of the severity of the impairment. We need to evaluate the effects of the lead toxicity on the child to determine whether the impairment is disabling, and, if so, whether the duration requirement is or will be met.

Question: Is there a blood lead level that denotes an allowance on a functional equals basis?

Answer: As explained above, the effect of lead toxicity varies from child to child, even at very high lead levels. If we were to specify a blood lead level that would be indicative of a disabling impairment in all children, that level would have to be set at too high a threshold to be useful in most cases. Therefore, any functional equivalence determination made in these cases should be based on the functional effects of the lead toxicity.

Question: Should current blood lead level testing be purchased if the child has been treated in the past and has exhibited no symptoms over a 1-to-2-year period?

Answer: As with any other situation in which a child is asymptomatic, current testing is not necessary merely to determine the status of the impairment. Additionally, even if the child were symptomatic, current blood lead level testing would generally not be necessary as it is the effects of the lead toxicity, not the blood lead level, which is evaluated to determine disability.

Question: Is developmental or psychometric testing mandated in these claims?

Answer: Developmental or psychometric testing will be needed when there is evidence suggesting or allegations of more than minimal limitations in areas assessed by this type of testing, the degree of limitation cannot be assessed based on the evidence in file, and this assessment is material to the disability determination.

DISABILITY DIGEST

Social Security Administration
Office of Disability

Code: DI 25205.010
Date: July 1993
Number: 93-11

Notice: All information presented in this issuance is instructive, clarifying or administrative in nature and does not represent new substantive rules that could reasonably be expected to have an impact on entitlement determinations.

Title: Title XVI Childhood Training Summary

Reference: See Below

Issue: This issuance is the first of a series which will present summaries of title XVI childhood training in individual disability determination services (DDSs) on topics of national interest. Publication of these summaries will enable all adjudicators to benefit from these training efforts.

The topics in this first issuance include:

- General development issues
- Preparing individualized functional assessments (IFAs)
- Failure to cooperate
- Communication impairments
- Asthma and the motor domain
- Growth impairments
- Older adolescents
- Obtaining school records
- Processing Zebley class cases
- SSA-831 coding
- Continuing disability reviews (CDRs)

The topics in this first issuance were addressed during training in the Washington, Maryland, District of Columbia and Kansas DDSs.

Discussion:

Development and Documentation

(Reference: POMS DI 25205.010)

In all the DDSs, we provided reminder items on general development and documentation issues. We said that we have a responsibility to initially develop evidence to document both the existence (or nonexistence) and severity of all alleged current impairments. (Of course, if the claim can be allowed on the basis of any one (or more) of the alleged impairments, development of other allegations can be ceased.) We also stressed the fact that explaining how the evidence was evaluated will result in better decisions.

The following reminders were discussed:

o Determining the Allegations

- All allegations of current impairment(s) must be developed initially. Keep in mind that all the allegations may not be contained on the SSA-3820 or SSA-3881. Allegations could be raised at almost any point; e.g., during a phone conversation or during a consultative examination (CE).

- In particular, be aware of situations in which the claimant has specifically alleged only physical impairments, but the file indicates the possibility of a mental impairment.

- This may occur, for example, when school records or activities of daily living (ADL) information indicates significant behavioral problems. Since most children engage in inappropriate behaviors from time to time, the fact that behavioral problems are mentioned does not always mean the child has a mental impairment. The adjudicator should document and review the frequency, duration, nature, pattern, and intensity of the behaviors. If this specific information indicates a potential mental impairment; i.e., the behaviors are outside the range of "normal," and the claim cannot be allowed without considering this potential impairment, evidence of a medically determinable impairment from an acceptable medical source will be necessary. (POMS DI 22505.003 and DI 24505.030.D.)

o Sources of Evidence

- We are responsible for developing a complete medical history in accordance with POMS DI 22505.001.C.6.

- This means we must make every reasonable effort to obtain evidence from every medical source who has information relevant to the claimant's impairment(s). We must also obtain sufficient evidence of functioning in order to properly assess the severity of the impairment(s), unless the case can be allowed based on criteria that do not include an assessment of functioning.

- Sources to be contacted will generally be listed on the SSA-3820. However, if appropriate sources are indicated elsewhere in the file, such as the SSA-3881 or SSA-795, they should be contacted as well.

- A question was asked as to whether the DDS can speak directly to the child claimant to obtain ADL information. If so, the DDS wanted to know if there is a minimum age below which the child is considered too young to provide reliable information. The DDS also asked if permission from the parent or guardian should be obtained prior to talking to the child.

- We stated that while it is usually preferable to obtain ADL information from an adult, this information can be obtained directly from the child if the child is capable of providing it. The child need not have attained any specific age; the DDS examiner will have to use his or her judgment as to whether the child is capable of providing the needed information. Obtaining parental permission to talk to the child is recommended, but there is no legal requirement that such permission be obtained.

- All evidence must be considered when determining impairment severity. Remember, lay sources, including the child's primary caregiver, can provide essential information on the child's abilities and limitations in everyday contexts.

- All efforts to contact sources must be documented in file (DDS development worksheet). (POMS DI 20503.001.C.)

- If a CE is required, be sure all relevant background material is sent to the CE provider in order to obtain the most balanced picture of how the claimant is functioning. (POMS DI 22510.016.C.1.)

- Resolving Conflicts

  - If there are conflicts in the file that are material to the decision, they must be resolved. If the evidence in file is insufficient to do this, the DDS should recontact the sources of the conflicting evidence for clarification of the evidence or additional or more specific information. Additionally, the DDS may need to contact other sources for corroborative information. If necessary, a CE can be purchased. Be sure to explain, in the IFA/rationale, how the conflict was resolved, including an explanation of how the evidence was weighed.

Preparing Individualized Functional Assessments (IFAs)

(Reference: POMS DI 25220.000ff.)

We commented to all the DDSs that our reviews of childhood claims have found that the content of Individualized Functional Assessments (IFA) could be improved to better explain or support the DDSs' conclusions. We offered the following reminder items and hints for better preparation.

- The IFA should summarize all evidence regarding a child's impairment, not only the evidence that the DDS has used to support its position. Inclusion of all the evidence will help reviewers know that an adjudicator has considered the entire body of evidence concerning a child's impairment, and will help to preclude any assumptions by reviewers that certain evidence was not considered and weighed. The DDS's conclusion thereby becomes less subject to criticism by reviewers.

- Descriptions of the child's functioning in the domains should say what the child can do, as well as what he or she cannot do, in order to draw a complete profile of the child's ability to function independently, appropriately, and effectively in an age-appropriate manner.

- Limitations in functioning must be related to a medically determinable impairment in order to be considered as examples of what a child cannot do. If a child has limitations in an area, and these limitations cannot be related to the established impairment(s), the adjudicator should determine whether another medically determinable impairment exists. For example, a 13-year-old boy whose established impairment is a congenital leg deformity also manifests problem behaviors of fairly recent onset which cannot reasonably be attributed to the established impairment. The adjudicator needs to determine whether the

behaviors are attributable to a medically determinable impairment. If additional development from treating or consultative sources were to document that the behaviors are a manifestation of the onset of puberty and within the range of normal adolescent behavior, the behaviors would not be attributable to a medically determinable impairment. Thus, these behaviors would not represent functional limitations in making the disability determination. If additional development from treating or consultative sources were to establish, on the basis of signs, symptoms, and laboratory findings, that the behaviors are a manifestation of a medically determinable impairment, then they would be evaluated through the childhood sequential evaluation process. If the impairment were found not be meet or equal a listing, whatever limitations it imposed would be assessed in the affected domains in an IFA.

- When indicating a rating of impairment-related limitations in a domain, adjudicators should check only one box in the domain; i.e., do not check two boxes with an arrow moving back and forth between the two boxes.

- When cognitive impairment is alleged and intelligence testing has been done, the cognitive domain should **never** reflect only the child's IQ results. Documentation of this domain in the IFA should include information concerning the child's academic achievement, and equally important, information about his or her cognitive functioning in activities and tasks outside school, e.g., at home, in play activities and games, in routine daily activities.

- IFA rationales in claims for older adolescents should reflect how the claimant's cognitive, communicative, social, and personal/behavioral functioning and his or her concentration, persistence, and pace in the completion of tasks affects the ability to do the basic mental requirements of at least unskilled work, and how the claimant's motor functioning and his or her concentration, persistence, and pace in the completion of tasks affects the ability to do the basic physical requirements of at least sedentary work.

- The IFA rationale should explain thoroughly how the DDS's conclusions were reached, i.e., how the ratings of limitations in the separate domains were reached, and how the overall conclusion regarding the child's ability to function age-appropriately was reached.

  The overall conclusion should be based on whether there is a substantial reduction in the child's ability to function independently, appropriately, and effectively in an age-appropriate manner, <u>not on how many domains are at least</u>

moderately limited. Remember, the term "moderate" represents a range of severity from just above "minimal" to just below "marked." The guidelines in POMS DI 25220.025C, that indicate that disability should generally be established if the child is moderately limited in at least three domains, assume three "good, solid moderates." (This issue was clarified in Q&A 4, question 1.) If the child does not meet this level of severity, the child should not be found disabled.

- The language used in IFA rationales and in quality case reviews to express the conclusion based on the IFA should reflect the regulatory definition of disability for children rather than the statutory definition. That is, rather than saying that, "the child's impairment(s) is (or is not) of comparable severity to one that would disable an adult," it is preferable to say that, "the child's impairment(s) does (or does not) substantially reduce his (or her) ability to function independently, appropriately, and effectively in an age-appropriate manner."

Failure To Cooperate

(Reference: POMS DI 23010.001, DI E22510.017ff and DI 25205.005A.5)

We discussed efforts that should be made in childhood cases in which the applicant for the child is not cooperating in getting the child to a CE or is not assisting in providing sufficient evidence. We reported that we are preparing written instruction on these issues and we offered the following general suggestions.

Because children are not generally in a position to pursue their own claims and take responsibility for cooperating with SSA, our instructions provide that in cases of noncooperation, "special efforts" must be made to identify and contact an adult responsible for the child's care.

When the applicant is not willing to take the child to a CE, the adjudicator should check the file to see if there are any other responsible adults (e.g., grandparent, other older siblings) living in the same household with the child who may be able to assist. If the file indicates that there is an agency with legal custody (e.g., child living with foster parent--state has custody rights), that agency is responsible for providing any needed information and must be contacted. Finally, the adjudicator could ask the applicant if he or she could recommend someone else

to assist if the applicant is unable/unwilling to do so. If a potential responsible party is identified, contact should be made with that person. We do not recommend going outside the household for assistance with a claim, except to an agency with legal custody.

Communication Impairments

(Reference: POMS DI 25220.010D.2.)

- Until new listings are available for the evaluation of communication impairments, we will rely on existing guidance concerning interpretation of Listing 111.09. This guidance is in memoranda sent to the Boston Regional Office (RO) on September 23, 1987, and to the Atlanta RO on December 8, 1987. The guidance is, in part:

  - A communication impairment that occurs in conjunction with a documented, causally-related neurological disorder meets the listing if the child's communicative functioning is at a level generally acquired by children who are no more than two-thirds the child's chronological age (CA).

  - A communication impairment that does not occur in conjunction with a documented, causally-related neurological disorder, nevertheless, equals the listing if the child's communicative functioning is at a level generally acquired by children who are no more than one-half the child's CA.

- We provided a response to the following question: "Double-weighing -- When is a low verbal IQ evaluated under the communicative as well as the cognitive domain?"

  Response: Verbal IQ scores should be used primarily to evaluate a child's mental abilities under the cognitive domain and should not be considered primary evidence for evaluating a child's communicative abilities. Although certain subtests (e.g., comprehension, similarities, vocabulary) used in obtaining a verbal IQ (VIQ) do measure aspects of language (e.g., verbal reasoning and semantics), they do not measure the full array of speech and language skills that constitute communicative ability.

  In some circumstances, a low VIQ score may suggest a limitation in a child's communicative functioning; e.g., the VIQ is significantly lower than the performance IQ, or there is a wide fluctuation in verbal subtest scores.

Asthma and the Motor Domain

(Reference: POMS DI 25220.010)

In several sessions, a question was asked as to the most appropriate domain in which to evaluate limitations resulting from asthma.

As we have stated in the past, once the evidence in file, from an acceptable medical source, documents that a child has a medically determinable impairment, we address all functional limitations imposed by the medical condition in whichever domains are affected. In an asthma case, it would appear the domain most likely affected is the motor domain. We discussed the scope of the motor domain, and reminded adjudicators that this domain addresses not only fine and gross motor skills, but all physical activities the child can and cannot do.

There was discussion of considering limitations in the child's ability to engage in physical activities under "chronic illness" in the "other factors" portion of the IFA. We pointed out that while the other factors are considerations to be kept in mind throughout the evaluation process, they are not separate domains. Any impact of the "other factors" (for example, adverse effects of medication which further reduce the child's ability to function) should be reflected in the domains and behaviors where we capture the full picture of a child's abilities and impairment-related limitations.

A child with asthma may also have some limitations in the social domain if he or she is unable to play with peers. The personal/behavioral domain could be restricted if the impairment restricts the child's ability to perform self-care skills, e.g., dressing or bathing. It is also possible that the child would be reduced in his/her ability to concentrate and persist in a given task or activity at a reasonable rate.

An adjudicator must remember that each case should be evaluated on its own merit, taking into consideration how the impairment(s) affects that particular child. All children are not alike and each child adapts differently to medical conditions/treatment.

Growth Impairments

(Reference: Listings 100.02 and 100.03)

We discussed the need for proper interpretation of the growth impairment listings and the importance of recognizing that mere shortness does not constitute a growth impairment. Short stature can be the result of a growth impairment but is not, in and of itself, a medically determinable impairment. We indicated that

the criteria in either Listing 100.02 or 100.03 are met only if there is an ongoing disease process present. The presence of an ongoing disease process is indicated by evidence which shows that a child's linear growth is continuing at a rate less than that expected; i.e., there is a decrease in age-appropriate increments and the growth curve continues to fall away from an expected channel. Thus, for example, a fall of growth to, or persistence of growth below, the third percentile without evidence of a continuing reduction in growth velocity does not meet the severity level intended under Listing 100.02.

Serial growth measurements are required to confirm these findings. When available, mid-parental heights can be helpful to approximate the expected growth channel and rate for age.

The DDS asked if there is a specified period of time that must elapse in order to show the child is continuing to fall away from the expected growth curve. We indicated that while there is no specified time period, a sufficient period of time must have elapsed to allow the adjudicator to predict whether the decline in the growth rate will last 12 months.

The growth impairment listings are no longer applicable once a child's major epiphyses have closed. The DDS asked how to document this, and we indicated that, generally, x-ray evidence should be obtained.

Older Adolescents

(Reference: POMS DI 25220.020E, DI 25205.010)

The childhood disability regulations recognize that older adolescents (aged 16 to attainment of age 18) are in a "transitional period" between childhood and adulthood. The regulations provide that youngsters in this age group will be evaluated in a manner appropriate to this transition. Thus:

- Inasmuch as older adolescents generally have the kinds of physical and mental abilities that young adults (age 18 and older) have, the activities and behaviors that are considered "age-appropriate" for older adolescents are those which are required in work-related physical and mental activities.

- Although we consider their work-related abilities, we do not evaluate older adolescents as we do adults, i.e., we do not follow steps 4 and 5 of the adult sequential evaluation process; we do not do a residual functional capacity assessment; and we do not use the medical/vocational rules.

- Nor do we rate the older adolescent's limitations in the functional domains as we do for younger children in order to make a disability determination.

- Rather, we organize a profile of the adolescent's functioning using the domains as a framework for the evidence, and then translate that profile into an assessment of the adolescent's ability to do the basic mental requirements of at least unskilled work and the basic physical requirements of at least sedentary work.

When an older adolescent has worked or is working, adjudicators should consider the employer to be an excellent source of description of the claimant's functioning on the job and in the work setting.

- If the employer is not a viable source of evidence, or if there is sufficient evidence of the adolescent's work-related abilities from other sources that will permit determination of the claim, it is not necessary to pursue evidence from the employer.

- However, given the potential value of the employer as an evidence source, if that source is not used, adjudicators should document all (futile) efforts to obtain employer evidence or all reasons for not seeking it.

Obtaining School Records

(Reference: DDS Administrators' Letter No. 180 dated 08/08/91)

The DDS asked if cases can be put on medical hold (deferral) in situations where schools are closed for the summer, the school records are not available, there are no other sources from which the needed information can be obtained, and the school records are needed to properly document the file.

We indicated that deferral is appropriate in this situation.

Processing Zebley Class Cases

(Reference: POMS DI 32597.010, DI 25220.000ff.)

One DDS questioned our instruction to prepare an IFA for the earliest age group covered by the application in those situations in which a child crosses age groups. The DDS indicated this is difficult in some Zebley class cases in which:

- the presumption cannot be applied,
- the prior file is not available,
- the file contains no evidence or insufficient evidence for the youngest age group applicable.

In this situation, the IFA should be based on the earliest age group for which sufficient evidence is in file. It is important to remember that evidence from a particular point in time may be used to make inferences about the child's functioning for a reasonable period of time prior to the actual date of the evidence. Therefore, the earliest age for which there is sufficient evidence may precede the age of the child at the time the evidence was recorded.

If an IFA cannot be completed for the earliest age group covered by the application, the IFA summary should include a statement indicating there is insufficient evidence to assess the child's functioning prior to the period shown on the IFA.

The DDS also wanted to know if the presumption can be applied if the field office has forwarded the prior file to the DDS.

We indicated the presumption can be applied provided the prior file does not contain contrary medical evidence or raise a medical judgment issue.

Type of Claim Coding on the SSA-831-C3

(Reference: POMS DI 20501.005B.8.)

One DDS is seeing cases in which the claimant is age 18 or older at the time of filing, but the type of claim is categorized as a disabled child (DC) claim. The DDS is also seeing cases in which the claimant is under age 18 at the time of filing, but the type of claim is categorized as a disabled individual (DI). The DDS

wanted to know if this coding determines whether the childhood or adult rules should be used; i.e., are the childhood disability rules applied to claimants age 18 or older who are categorized as DCs, and are the adult rules applied to claimants under age 18 who are categorized as DIs. If not, the DDS wanted to know if they should correct the coding.

We told the DDS that the type of claim coding does not dictate which rules should be used to determine disability. The adult rules should be applied if the claimant is age 18 or older at the time of filing. The childhood disability rules should be applied to every title XVI claimant who is under age 18 at the time of filing. (We note the cited reference directs adjudicators to apply the adult rules to title XVI claimants who are under age 18 if they are categorized as DI. We will issue a correction to this section as soon as possible.)

The type of claim coding is used for determining other aspects of the SSI program, such as income and resources and benefit amounts, and is based not only on the claimant's age, but also on other factors such as his or her living arrangements and student status. Therefore, this coding should not be changed by the DDS, unless the DDS determines the claimant is statutorily blind. In that situation, the DDS should change the "DI" or "DC" to "BI" or "BC" respectively.

Continuing Disability Reviews (CDRs)

(Reference: POMS DI 28000.000ff.)

A DDS requested clarification on how to apply the medical improvement review standard in situations in which:

- the child's most recent favorable determination was based on having an impairment that met/equalled the growth impairment or hearing listings;
- the child's functional limitations were determined by comparing the claimant's functioning to that of an unimpaired child; and
- the claimant is now an adult but was a child (i.e., under age 18) at the time of the most recent favorable determination.

In response to this question, the CDR process for title XVI claims was reviewed. As each step was discussed, the concerns of the DDS were addressed as indicated below.

Step 1--Does the claimant's impairment meet/equal a current listing? (DI 28005.015)

- If the claimant is now an adult, only the Part A listings are considered at this step, and functional equivalence does not apply.

- If the claimant is still a child, consider both Part B and, where applicable, Part A listings. If the Part B listings contain age criteria, use the criteria applicable to the child's current age. For example, a child was entitled at age 4 based on having an impairment that met Listing 102.08. That listing has one set of criteria for children under age 5, and another set of criteria for children age 5 and older. If a CDR were to be conducted when the child was age 12, the second set of criteria would be used at this step.

- This determination considers all the claimant's current impairments, not just those present at the comparison point date (CPD); i.e., the date of the most recent favorable determination.

Step 2--Has medical improvement (MI) occurred? (DI 28010.001ff.)

- MI is any decrease in the severity of any impairment that was present and documented at the CPD. To determine if MI has occurred, we look for improvement in signs, symptoms, and/or laboratory findings. The terms "signs," "symptoms," and "laboratory findings" include functional limitations that were documented at the time of the CPD.

- Growth Impairments--Listings 100.02 and 100.03 require a continual falling away from expected growth velocity. MI will occur when the child no longer experiences this requisite continuing fall-away.

- Hearing Impairments--MI can be found in situations in which the hearing threshold level has not changed if the impact of the hearing impairment has lessened. For example, suppose that, at the CPD, the file was documented to show that the child's decreased hearing affected the clarity of his or her speech. If the clarity of the child's speech has improved by the time of the CDR, MI can be found even if the hearing threshold level has remained the same.

- Limitations in functioning--Some limitations in functioning are assessed by comparing the child's functioning to the level of functioning demonstrated by unimpaired children of the same age. To determine if MI has occurred, the child's current functioning in these areas should be compared to the

functioning of unimpaired children of the child's current age. If the degree of limitation has lessened, MI has occurred.

Step 3--Is MI "related to the ability to work" (in children, the ability to function independently, appropriately, and effectively in an age-appropriate manner)? (DI 28015.001ff.)

- If, at the CPD, the claimant's impairment met/equalled a listing and the claimant's impairment has improved so that it no longer meets/equals that listing as it appeared at the time of the CPD, the claimant's MI is "related to the ability to work."

- If the claimant's impairment met/equalled a Part B listing at the CPD, and the claimant is now an adult, apply the criteria of the prior listing that would be applicable to a child just before age 18 in order to determine if the claimant's impairment continues to meet/equal the prior listing.

- If the claimant's impairment previously met/equaled a listing, consider functional equals when determining whether the claimant's impairment continues to meet/equal that same listing, even if the claimant is currently an adult. (This is the only instance in which functional equals would be considered in the case of an individual who is now an adult.)

- If the CPD decision was based on an individualized functional assessment (IFA), and the claimant is still under age 18, prepare a current IFA based on the child's age now, considering only the impairment(s) present at the CPD. Compare the IFAs to determine if there has been improvement in the child's ability to function. If yes, find that there has been MI "related to the ability to work." (If no, the MI is not "related to the ability to work" and, if no exception applies, benefits will be continued. If there is evidence of a new impairment since CPD, another IFA which considers the effects of all impairments should be completed to document the file for the next CDR.)

- If the CPD decision was based on an IFA, and the claimant is now an adult, the action needed will depend on the age of the child at the CPD.

    1. If, at the CPD, the IFA was based on limitations in the domains, prepare a current IFA, considering only the impairment(s) present at the CPD, as though the claimant were just under age 18. Compare the IFAs and, if there has been improvement in the claimant's ability to function, find MI related to the ability to work.

(If there is no improvement, the MI is not related to the ability to work and, if no exception applies, benefits will be continued. A residual functional capacity (RFC) assessment which considers all impairments should be completed to document the file for the next CDR.)

2. If, at the CPD, the IFA was based on work-related activities, prepare a current RFC assessment considering only the impairment(s) present at the CPD, and compare this to the IFA. (Again, if there is no improvement, the MI is not related to the ability to work and, if no exception applies, benefits will be continued. If there is evidence of a new impairment since CPD, prepare an additional RFC that considers all impairments.)

Steps 4 & 5--Is the claimant currently disabled? (DI 28005.001ff.)

- If there is MI "related to the ability to work," a determination is needed as to whether the claimant is, nevertheless, currently disabled. This determination utilizes the criteria for initial claims and considers all current impairments, not just those present at the CPD.

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DISABILITY DIGEST

Social Security Administration

Office of Disability

Code : DI 24515.001
Date : November 1993
Number: 93-14

Notice: All information presented in this issuance is instructive, clarifying or administrative in nature and does not represent new substantive rules that could reasonably be expected to have an impact on entitlement determinations.

Title: Resolution of Internal Inconsistencies in Medical Reports

Reference: DI 22505.008, DI 24515.001

Issue: What action should the adjudicator take when there is an inconsistency in a medical report between the source's medical findings and medical opinion(s), such as a medical source statement (MSS)?

Discussion: The CE/MER regulations and implementing POMS instructions require adjudicators to, among other things, analyze each piece of relevant evidence for internal inconsistency. An important internal inconsistency is when the medical findings that a medical source reports are inconsistent with the medical opinion(s), which interprets those findings, offered by the source on the nature and severity of the claimant's impairment(s), such as diagnosis, prognosis, or frequently an MSS. For example, the medical findings will suggest significantly greater or lesser severity of impairment than is expressed in an MSS.

If there is an inconsistency in a medical report that is not material, i.e., an inconsistency that would not have an effect on the ultimate outcome of the case or any of the major conclusions (such as assessment of residual functional capacity, evaluation of pain), then it is not required to attempt to recontact the medical source to try to resolve the inconsistency. Whenever there is a **material** inconsistency in a medical report, however, the adjudicator must attempt to recontact the medical source to try to resolve the inconsistency. The medical source's opinion cannot be properly weighed without an attempted recontact to obtain additional evidence--which may consist of nothing more than a more detailed explanation--in support of the opinion or to resolve the conflict.

Without this attempt, it is not acceptable to say that the medical opinion is being given "little weight" or "no weight" simply because the opinion is inconsistent with the source's medical findings. Conversely, without the attempted recontact, it is not acceptable to say that a treating source's opinion is being given "controlling weight," or "more weight" than the opinion of a nontreating or nonexamining medical source, simply because the opinion came from a treating source when that opinion is inconsistent with the treating source's medical findings.

If the attempted recontact is unsuccessful, e.g., when the medical source refuses to provide additional evidence, the adjudicator will have no choice but to make the best decision possible despite the unresolved conflict based on a weighing of all the evidence and a decision as to which evidence should get the greatest weight.

DISABILITY DIGEST

Social Security Administration
Office of Disability
SSA Pub. No. 64-050

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Date: March 1994
Number: 94-6

Notice: All information presented in this issuance is instructive, clarifying, or administrative in nature and does not represent new substantive rules that could reasonably be expected to have an impact on entitlement determinations.

Title: Second Title XVI Childhood Training Summary

Reference: See Below

Issue: This issuance is the second of a series which will present summaries of title XVI childhood training in individual disability determination services (DDSs) on topics of national interest. Publication of these summaries will enable all adjudicators to benefit from these training efforts.

This second issuance summarizes the training sessions that were held in the Missouri, Iowa, Nebraska, Tennessee, Minnesota, Delaware, Pennsylvania, and West Virginia DDSs. Although these sessions included discussions of many of the topics that were covered by the first issuance No. 93-11, this issuance will summarize only the material that was not included in the first issuance.

The topics included in this issuance are:

- General Development
- Issues Involving Behavior
- Communication Impairments
- Assessing Cognitive Functioning
- Down Syndrome
- Seizure Disorders
- Functional Equivalence
- Miscellaneous Issues

Discussion:

General Development Issues

(Reference: POMS DI 25205.010)

Secondary mental/emotional/behavioral problems

In several DDSs we discussed what development should be considered when a parent alleges a possible mental impairment due to medication prescribed for a physical impairment, or emotional/behavioral problems secondary to a physical impairment.

Functional limitations that are not due to a medically determinable impairment are not assessed in a disability determination. On the other hand, once a medically determinable impairment is established **that could reasonably cause** the child's limitations, it is not necessary to determine whether the child has other impairments that are also causing the same limitations.

- For example, a parent may allege that a child's asthma medication makes the child hyperactive. Once the presence of the hyperactivity has been confirmed with appropriate documentation, the treating physician should be contacted to verify whether the hyperactivity can **reasonably be attributed** to the asthma medication. If it can (and this would be explained in the Other Factors section under side effects of medication), then it would not be necessary to establish a mental impairment. Functional limitations related to the hyperactivity should be evaluated in the affected domains in an Individualized Functional Assessment (IFA).

- In another example, a parent may allege that a child with a history of otitis media has speech and language problems that impair communication and engender emotional/behavioral problems. Once the presence of the emotional/behavioral problems has been confirmed by appropriate documentation, the treating physician should be contacted to verify whether the behavioral difficulties can **reasonably be attributed** to the otitis media and communication impairment. If they can, then it would not be necessary to establish a mental impairment. Functional limitations related to the emotional/behavioral problems should be evaluated in the affected domains in an IFA.

Activities of Daily Living

We were also asked to discuss development of activities of daily living (ADLs).

ADL development should be tailored for the alleged impairment(s) and the resulting limitations. Adjudicators are not required to

obtain evidence to verify that the claimant does not have limitations in areas for which limitations are neither alleged nor indicated in file.

- Request for information should be as specific and concrete as possible so that responses from evidentiary sources are also specific and concrete. For example, general questions such as, "How does the child get along with others?" may elicit general statements such as, "the child is disruptive" or "the child fights." Such responses do not provide sufficient information to determine what behaviors the child is exhibiting or how serious they are. Additionally, words like "frequently," occasionally," and "often" are less helpful in determining how often the child exhibits these behaviors than are more concrete descriptors (e.g., 2-4 hours a day, 6-8 times a day). (See Childhood Disability Hotline Questions and Answers, issuance #13, item 2., for further discussion.)

Issues Involving Behavior

(Reference: POMS DI 25220.010)

We discussed 2 issues involving assessment of behavior: Conduct Disorders, and the distinction between the social and personal/behavioral domains.

Conduct Disorders

The DSM-III-R defines mental disorder, in part, as a manifestation of a behavioral, psychological, or biological dysfunction in a person which is " . . . associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom." It further specifies that " . . . neither deviant behavior, e.g., political, religious, or sexual, nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the person. . . ."

In the DSM-III-R, there are three types of mental disorders known as "Disruptive Behavior Disorders": Conduct Disorder, Oppositional Defiant Disorder, and Attention-deficit Hyperactivity Disorder. Conduct Disorder is characterized by a "persistent pattern of conduct in which the basic rights of others and major age-appropriate societal norms or rules are violated."

Since Conduct Disorder is a diagnosable mental disorder, it is a medically determinable impairment. However, not all disturbed/disturbing behavior constitutes a Conduct Disorder.

For example, membership in a gang and gang-related behavior do not, by definition, constitute a medically determinable impairment; a person does not necessarily have a Conduct Disorder just because he/she participates in a gang.

Some individuals who belong to gangs may, because of persistent violation of the basic rights of others and of major age-appropriate societal norms or rules, be candidates for a diagnosis of mental pathology (e.g., Conduct Disorder, Group Type), and the gang and its activities may constitute a vehicle for their acting out pathologically based behavior.

Other individuals within gangs may manifest what the DSM-III-R calls "Childhood or Adolescent Antisocial Behavior" (CAAB), which is characterized by isolated antisocial acts rather than persistent, repetitive patterns of negative, destructive behavior; however, CAAB is not attributable to a mental disorder in the DSM-III-R and is not a medically determinable impairment.

It is similarly important to sort out whether disruptive behavior at school or home constitutes a medically determinable impairment. Some children, because of significant behavioral, psychological, or biological dysfunction, may behave in disturbed/disturbing patterns which prompt therapeutic intervention within or outside the school to address emotional and behavioral problems. Still other children may behave disruptively and unacceptably from time-to-time or in particular situations, but may not be found to manifest significant behavioral, psychological, or biological dysfunction. When a diagnosis has been assigned to a child's behavioral problems, it is important to ensure that there is sufficient evidence to substantiate the diagnosis. The underlying nature of a child's behavior must be carefully distinguished in order to identify those children who do experience a medically determinable impairment. Of course, when a medically determinable impairment exists, the impairment may or may not be disabling; the severity of the impairment must be carefully documented and the adjudicative conclusions explained in the rationale or IFA.

Social vs. Personal/Behavioral Domains

In the IFA, the domain of social functioning addresses a child's ability to relate to other people--family members, both parents and siblings, children in the neighborhood and at school, teachers and other adults. It involves the capacity to initiate, develop, and maintain relationships, which starts in early infancy in the bonding of infant to caregivers and becomes increasingly complicated as the child develops and grows older.

The domain of personal/behavioral functioning, specifically the area of self-control, addresses the child's capacity to inhibit and control destructive attitudes, impulses, and behaviors (toward self, other people, animals, or property) in order to cope successfully with the expectations, limits, and rules of the child's various environments.

Given this distinction, it is appropriate to evaluate in the social domain the child's ability to relate satisfactorily to other children and adults, or his/her difficulty and frustration in not relating satisfactorily to other children and adults. It is appropriate to evaluate in the personal/behavioral domain behavior that is impulsive, hostile, aggressive, or harmful to the child himself, or to other people, animals, or property. This would include the child's difficulty in accepting and complying with persons in authority both in and outside school. For example, behaviors typically identified in Oppositional Defiant Disorder or Conduct Disorder would be appropriately evaluated in the personal/behavioral domain.

Assessing Cognitive Functioning

(Reference: Listing 112.05, POMS DI 25220.010)

Discussions on this topic concerned the application of Listing 112.05 and rating the cognitive domain in an IFA.

Listing 112.05

Listing 112.05 requires the establishment of mental retardation (MR). A low IQ score alone does not establish mental retardation. **Deficits in adaptive functioning** are part of the definition of MR and must be consistent with a person's IQ scores. Therefore, Listing 112.05 cannot be met unless an individual manifests **both** significantly subaverage general intellectual functioning and deficits in adaptive functioning. (Childhood Disability Hotline Questions and Answers, Transmittal Number 7, Question 1, addresses this point in more detail.)

Rating the Cognitive Domain

Standardized intelligence test scores are useful in helping assess a child's cognitive abilities, but they must be accompanied by achievement test scores when academic performance is an issue, and by descriptive information about a child's cognitively based functioning on a daily basis. A child may function either **above or below** the level one would expect based on intelligence test scores alone; so, functional indicators of the child's abilities and limitations must not be ignored.

- A child with low IQ scores who nonetheless demonstrates relatively strong cognitive abilities in his or her day-to-day functioning may be found **less** limited than one would expect based on test scores alone.

- It is also possible for a child with higher IQ scores to be unable to perform cognitively based tasks in an age-appropriate manner on a daily basis. This child would be found **more** limited than one would expect based on test scores alone.

If the functional evidence seems inconsistent with test scores, the inconsistency must be resolved, and all the evidence must be weighed in order to decide what the child's true limitations and abilities are. The IFA case summary should explain how the evidence was weighted and why.

Communication Impairments

(Reference: POMS DI 25220.010D.2)

In each DDS we presented a "primer" on communication impairments. The following definitions and basic concepts were discussed.

- **Communication** is the process of exchanging information or ideas; it consists of four components: hearing, speech, receptive language, and expressive language.

- **Development of communicative skill** begins at birth and follows recognizable patterns in the maturation of articulation and receptive and expressive language. Children acquire discrete communicative skills over a period of time that is considered the "normal range" for that particular skill. Some children may manifest particular skills quite early in the period appropriate for the appearance of those skills, while other children may be "late bloomers," manifesting the same skills quite late in the period, but nevertheless, remaining normal in their communicative development.

- **Communicative impairment** occurs when a child's communicative skills are below those expected at the child's age, and may occur in hearing, speech, receptive language, or expressive language, or in any combination of these.

- **Hearing impairment** that is prolonged (e.g., congenital hearing loss) or recurrent (e.g., chronic otitis media) may affect development of speech as well as receptive and expressive language skills. Hearing impairment before age 2 (even losses or deficits as little as a 25 db loss) may seriously affect development of speech and language.

- **Speech impairment** (disorders of articulation, voice, or fluency) may be due to various factors, and may or may not be accompanied by impairment of language ability.

- **Language impairment** may involve receptive deficits (difficulty comprehending language) or expressive deficits (difficulty producing language), or both, and may involve problems related to any of the elements of language (i.e., form [phonology, morphology, syntax], content [semantics], or use [pragmatics]); a language impairment may or may not be accompanied by a speech impairment.

- **Documentation** of the presence of a medically determinable communication impairment must be obtained from an acceptable medical source (e.g., pediatrician, neurologist, psychiatrist, otolaryngologist, psychologist). Documentation of the severity of a communication impairment should be obtained from sources familiar with the development of hearing, speech, and language in children (e.g., speech/language pathologist, pediatrician, pediatric neurologist, pediatric psychiatrist, pediatric psychologist, otolaryngologist, audiologist).

  - Document **hearing impairment** according to 102.00 of the Special Senses and Speech Listings.

  - Document **speech impairment** in infants and toddlers with descriptions of the child's oral-motor behavior (e.g., early sound history, oral-motor behavior while eating, ability to imitate speech sounds) and current sound repertoire. For children of preschool age and older, obtain descriptions of oral-motor functioning and evaluation of articulation, including intelligibility ratings, at the single-word and conversational levels.

  - Document **language impairment** with a professionally administered diagnostic battery including standardized tests and informal procedures that evaluate the child's proficiency (both receptive and expressive) in form, content, and use.

  - Obtain **descriptive information** from caregivers, teachers, and others who communicate with the child and can describe the child's actual, spontaneous communicative functioning on a day-to-day basis.

  - Necessary documentation may already be available in **medical evidence of record** if claimant is a school-age child who receives speech/language therapy at school, or a preschool child who has been identified and examined through an early intervention or preschool program. Claims that would usually require the

purchase of a speech/language examination include those for children for whom a communication disorder is alleged but who have not been previously identified and examined for communication disorder by a specialist.

- **Evaluation** is based on results of standardized test instruments; clinical observations by health care professionals, especially speech/language pathologists; and anecdotal descriptions of the child's communicative performance during ADL.

  - **Standardized test results** should be expressed in terms of standard deviations, standardized scores, or percentiles; raw test scores must be translated into one of these types of scores; a test score that is more than 2 standard deviations below the mean, or a standard score that is below 70, or a ranking below the 3rd percentile -- in conjunction with corroborative descriptions of a child's actual communicative functioning -- indicate at least a marked limitation of communicative functioning.

- **Evaluate** communicative impairments **at listing level** as follows:

  - When attributable to **anatomical defect**, evaluate under Listing 2.09.

  - When attributable to **hearing impairment**, evaluate under Listing 102.08B3 (with equivalence determinations for children under age 5).

  - When attributable to **neurological dysfunction**, evaluate under Listing 111.09. (See Disability Digest 93-11 for discussion of how to use Listing 111.09.)

  - When a communicative impairment involving language comprehension or production cannot reasonably be attributed to a physical disorder, evaluate under the childhood mental disorder listings.

- **Evaluate** communicative impairments in an **IFA** as follows:

  - Give **equal weight to all four components** of communication (hearing, speech, receptive language, expressive language). For example, demonstrated "marked" limitations in **any one of the four components** could produce an overall rating of "marked" limitation in the communication domain as a whole.

  - If more than one component is affected, do an overall assessment of the domain. If more than one component is affected to a moderate degree, the

overall assessment may find a "more significant" moderate limitation or a marked limitation. This will be determined on a case-by-case basis, based on the actual resulting functional limitations experienced by the child.

- **Developmental speech and language disorders are found in the DSM-III-R, and psychiatrists and psychologists can and should evaluate them. However, disorders that are neurological or anatomical in origin are considered somatic, and an M.D. has to evaluate them.**

Down Syndrome

(Reference: Listing 110.06, 110.07, POMS DI 24575.901)

We were asked to discuss the evaluation of Down Syndrome (DS).

When laboratory reports of genetic testing are not clear, or when genetic testing of a child is not extensive enough to confirm a diagnosis of mosaic or non-mosaic (DS), evaluate the child's claim using the following guidelines:

If the report of laboratory tests is not clear as to the chromosomal analysis, but the report does state that the child has DS (e.g., in interpretive or diagnostic remarks), determine that the child's impairment meets Listing 110.06. State the sentence in 110.00B which says: "Medical evidence that is persuasive that a positive diagnosis has been confirmed by appropriate lab testing, at some time prior to evaluation, is acceptable in lieu of a copy of the actual lab report."

If the report of laboratory tests is not clear as to the chromosomal analysis, and the report does not include any statement indicating that the child has DS, make a phone call to the lab or, if applicable, to the child's treating source for possible clarification of the lab tests and diagnosis (consider that the child's impairment **may** meet Listing 110.06, depending on the outcome of the recommended contacts). Complete a Report of Contact for signature and folder documentation.

If there is sufficient MER to demonstrate multiple body dysfunctions, consider the child's impairment under Listing 110.07 (a child with DS or other hereditary, congenital, or acquired condition may start to exhibit developmental delays by 6 months of age).

If there is sufficient MER to demonstrate mental retardation, consider the child's impairment under Listing 112.05.

If the MER is sufficient to establish that the child has a medically determinable impairment but impairment severity is not at listing level, do an IFA of the child's impairment(s).

If the evidence in file is not sufficient to make a disability **determination**, consider sending the child for proper genetic testing (not a full CE, only laboratory testing).

If for some reason laboratory test results cannot be obtained, and the child is too young for one to be certain of the existence or extent of developmental delays, a **short** medical deferral is possible, but not recommended. If a child has non-mosaic DS, he or she is disabled, and a deferral would delay benefits for which the child is eligible.

Seizure Disorders

(Reference: POMS DI 24515.035)

In response to several DDSs' questions about seizure disorders, the following is an overview of the documentation and evaluation of these disorders.

- When seizure disorder is alleged, the file must establish a medically determinable impairment with evidence from an acceptable medical source. In addition, the seizure disorder must be substantiated by **at least one detailed description of a typical seizure** (from physician or health care professional, if available, or by parent or other reliable observer).

- Documentation should include a **neurological examination** and a report of **EEG** results **if** an EEG is a part of the child's clinical records. A sleep EEG is preferable, when available, especially with temporal lobe seizures (§ 111.00A. of the Listing).

    - If an EEG is not available in the medical evidence of record, purchase of an EEG in seizure disorder is not routinely recommended because an EEG is often not definitive proof of a seizure disorder; conversely, a normal EEG, in and of itself, is not conclusive evidence that a seizure disorder is not present. We do not intend, however, that an EEG never be purchased. Each case must be evaluated individually, with careful medical consideration regarding whether an EEG should be purchased.

    - EEGs are useful from a diagnostic standpoint, but are of limited use in establishing disability. Disability due to epilepsy is established on the basis of frequency of seizures and the claimant's functioning, not on what the EEG shows.

- The longitudinal treatment source's record is usually the most complete and reliable source for documenting the presence, frequency, and severity of a seizure disorder.

- Nonmedical sources, including parents, caregivers, and school officials, may serve as important sources of information and should be contacted as a part of case documentation.

• To be disabling at **listing-level**, a seizure disorder must persist despite at least 3 months of prescribed therapy, and the claimant must have an ongoing relationship with a treatment source. If a severe impairment is not established at listing-level, all evidence must be evaluated to determine severity and an **IFA** (see POMS DI 24515.035).

• Although seizure disorders can frequently be controlled with the proper use of **drug therapy**, not all claimants may be under **optimal treatment**. Disability evaluation by the adjudicator is limited only to whether the claimant is adhering to the therapy that has been prescribed, and not whether the therapy is optimal, or what the claimant's condition would be if he/she were given optimal medical treatment.

• Anti-convulsant drug levels can be helpful in documenting **compliance with prescribed treatment**. However, sub-therapeutic blood levels may be caused by a variety of factors, and no presumption of noncompliance should be made solely on the basis of anti-convulsant drug levels. In all cases, drug levels should be evaluated in conjunction with all other case evidence in determining the question of compliance with prescribed treatment.

• The occurrence of more than one **minor motor seizure** per week is one determinative criterion for allowance under Listing 111.03. However, the frequency of minor motor seizures that occur at less than listing-level but which, nevertheless, constitute a **severe impairment**, cannot be stated in an absolute rule.

- In contrast to major motor seizures, minor motor seizures are usually brief, transient events or absences that frequently go unrecognized, and may occur more frequently than is evident to either the child or others.

- Postictal phenomena are often practically nonexistent, and most often a child who has these seizures can continue with the activity he or she was performing at the time of the seizure.

- Some children, particularly older children, do have what are called psychomotor seizures, with more than just a momentary loss of awareness, and which may involve an

aura, ictal and postictal activity, and even some abnormal behavioral manifestations.

- Listing 111.03 is based on the presumption that if minor seizures, particularly those that involve an alteration of awareness or loss of consciousness, are observed to be happening once a week or more, the actual frequency is probably higher, and that such a level of seizure activity is bound to cause restrictions in daily activities.

- At lower frequencies, and depending on the duration and other manifestations of the individual episodes, there may or may not be serious functional effects. A minor motor seizure disorder of **less than listing-level severity** may or may not be a severe impairment.

- If a minor motor seizure disorder causes **more than a minimal limitation** in a child's ability to function independently, appropriately, and effectively in an age-appropriate manner, the impairment is severe.

- If a minor motor seizure disorder does **not** cause more than minimal limitations, the impairment is not severe.

Functional Equivalence

(Reference: POMS DI 25215.015)

Several DDSs asked that we review the concept of functional equivalence.

Any medically determinable impairment, or combination of such impairments, can be found equivalent to any listing, so long as the **disabling functional consequences** of the impairment(s) are the same as those associated with the condition in the listing. There is no requirement that the impairment(s) being evaluated and the impairment cited in the listing be medically related. Difficulties arise because it is not always clear what the disabling functional consequences of a listed impairment are. Most listed impairments have disabling functional consequences, but they are not always spelled out.

- The mental disorders listings are very explicit regarding functional consequences, and a physical impairment or combination of physical and mental impairments can be functionally equivalent to one of the mental disorders listings.

- More judgment is required in considering whether an impairment is functionally equivalent to a listing described more in terms of medical findings than in terms of a person's functioning.

The following examples illustrate, respectively, inappropriate and appropriate application of the functional equivalence principle.

- Listing 101.02B is for **juvenile rheumatoid arthritis with steroid dependency**. This listing was written for children who not only have a very serious impairment, but who also exhibit the debilitating side-effects of continual high doses of steroids. A recent inappropriate use of the listing for a functional equivalence determination was in the case of a child with asthma, under fairly good control, who needed to keep prednisone on hand for the occasional bad day. This child did not have listing-level problems from either the impairment or the treatment and, thus, did not display the disabling functional consequences implicit in the JRA listing (see Miscellaneous Issues below).

- A child with breath-holding spells that resulted in frequent loss of consciousness was found to have an impairment that functionally equals Listing 111.03 (minor motor seizures). It was unclear whether this child's impairment was neurological in origin, but it was very clear that the **consequences** were similar--her breathholding was involuntary, and despite efforts to treat them, the spells were frequent enough and severe enough that they seriously interfered with her ADLs, to the same degree that would be expected of a minor motor seizure disorder.

Miscellaneous Issues

Several miscellaneous issues also came up in several states:

- **Determining the duration of an impairment**
  (Reference: POMS DI 22505.020)

Under title XVI (as well as title II), the determination of duration of an impairment does not start as of the date of application but, rather, from the point in time at which the impairment is first disabling. This **may be at any time prior to the month of filing**. Under title II, benefits are payable no more than 12 months prior to the month of filing. Under title XVI, eligibility for benefits begins with the date of filing.

Therefore, under title XVI, if the child is not currently disabled, but was disabled as of the date of application and had been for at least 12 months, a closed period of disability would be appropriate, with payment of at least some portion of one month's benefits and two additional months' benefits.

- **Visual-motor integration**
  (Reference: POMS DI 25220.010)

Visual-motor (eye-hand) coordination is an extension of fine motor coordination and, therefore, would be appropriately evaluated under the motor domain in an IFA. The concept of visual-motor coordination involves the coordination between what one perceives through vision and the motor responses required. Visual-motor coordination is distinct from purely visual defects as well as from purely motor defects and must be considered independently.

- **Steroid dependency and asthma**
  (Reference: Listing 101.02.B.)

Steroid dependency in children occurs in chronic, progressive impairments, the signs and symptoms of which may be temporarily relieved by steroid usage (e.g., Nephrotic Syndrome); however, when steroids are withdrawn, the individual's symptoms and signs related to the medical impairment being treated return and interfere with expected age-appropriate functioning. In contrast, asthma is not usually considered a chronic, progressive disease. Acute attacks that may occur episodically may be treated with steroids; however, once the attack is over, the steroids can be either drastically reduced or eliminated without the child's experiencing untoward effects. Therefore, in cases in which steroids are used primarily to treat episodic conditions such as asthma, such individuals would not be considered "steroid dependent," and their impairments would not be found to meet, medically equal, or functionally equal Listing 101.02B.

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DISABILITY DIGEST

Social Security Administration

Office of Disability

SSA Pub. No. 64-050

Code : DI 22505.006
Date : April 1994
Number: 94-13

Notice: All information presented in this issuance is instructive, clarifying or administrative in nature and does not represent new substantive rules that could reasonably be expected to have an impact on entitlement determinations.

Title: Title XVI Case Study Issue - Medical Source Statements in Title XVI Disabled Child Claims

Reference: DI 22505.006 and DI 25205.010

Issue: Must Medical Source Statements (MSS) Be Requested in Title XVI Childhood Disability Cases?

Discussion: Yes. In accordance with § 416.912 of the regulations and POMS DI 22501.001, a claimant is responsible for providing medical and other evidence of disability. Our responsibility, however, is to make every reasonable effort to help the claimant obtain the medical reports from his or her medical sources. A claimant's medical sources, especially a treating source, may have the most knowledge about the claimant's impairment and may be able to provide details of the claimant's condition over the longest period of time.

Section 416.913 and POMS DI 22505.006 explain that medical reports should include a medical history, clinical findings, laboratory findings, treatment prescribed (and the response to the treatment), diagnosis, prognosis, and an MSS which describes what the claimant can still do despite his or her impairment(s). In the case of a child filing for title XVI disabled child benefits, the MSS should contain the source's opinion about the child's physical and mental abilities to function independently, appropriately, and effectively in an age-appropriate manner and to perform age-appropriate daily activities. POMS DI 25205.010 contains a discussion of the kinds of activities on which a medical source should be asked to offer an opinion in these cases.

POMS DI 22505.006B.5. explains that the cover letter sent to a medical source will request a report which contains the medical history, clinical findings, and the other elements mentioned above, including an MSS. If the medical source fails to provide an MSS, the medical report is not incomplete. However, if it is subsequently determined that information about a functional limitation(s) is needed to adjudicate the claim, request that specific information (DI 22505.035B.4.).

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NOTES:

* Listing 10.10 was moved to Listing 9.09 on 7/2/93.

** Q & A issued prior to publication of new Respiratory Listings on 10/7/93.

"INTERIM FINAL" identifies discussions based on the functional equivalence examples in the interim final regulations. The final childhood disability regulations were published on 9/9/93. The final regulations renumbered and modified the wording of several functional equivalence examples in Section 416.926a.

PREPARED BY: Disability Programs Branch
San Francisco Region
October 1993

10/1/93

This is the sixteenth installment of the Childhood Disability Hotline Questions and Answers (Q & A). There are seven questions organized under five topic headings in this transmittal.

Inquiries about these Q & A should be addressed to the RO Zebley Coordinators. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf at (410) 965-9245.

Etiology of a Cognitive Impairment

1. Question: When you have acceptable medical evidence of a cognitive impairment, but do not know the etiology of the problem, and there is no available evidence of a child's physical condition, is it necessary to obtain a medical examination in order to inquire into a possible physical cause for the problem or to find out whether an unknown physical condition contributed to the problem? (Chicago On-Site Visit, (8/5-7/91)

   Answer:

   Generally, once it has been established that a child has a medically determinable impairment, such as a cognitive impairment, the etiology of the impairment is relatively unimportant as long as we are able to ascertain the physical and mental functional limitations the impairment imposes on the child. However, in cases where there is a question as to the correct onset date or whether duration is met, knowing the etiology of the impairment may help resolve the issue(s).

School Absences--Relationship to Severity of Impairment

2. Question: Please clarify the impact of school attendance or non-attendance in assessing severity. School attendance is one factor which is considered under Other Factors. There is nothing specific regarding quantification in the POMS guidelines, DI 25220.015J. For example, if a parent or caretaker keeps an asthmatic child home from school during inclement weather as a preventative measure, and the child is missing one or two days of school per week, how much weight should this factor be given in the overall decision? (Chicago, 11/1/91)

   Question: Please provide guidance about how to evaluate absences from school. (Atlanta On-Site Visit, 10/22-23/91)

Answer:

School attendance, in and of itself, is not used to assess the severity of an impairment. Rather, it is the effects of non-attendance, if such non-attendance is caused by the medically determinable impairment, that must be considered when evaluating the severity of a child's impairment(s). For example, a child who is frequently absent from school due to a medically determinable impairment may have difficulties in several areas, such as academic achievement and socialization. When present, these limitations would have to be considered when assessing the impairment even though these types of limitations might not ordinarily be associated with the impairment. On the other hand, there may be some children who have no detrimental effects from frequent absences. Where the absences do not cause more-than-minimal limitations in any of the domains or behaviors or, for older adolescents, on the child's ability to perform work-related activities, absences would not impact on the disability determination.

Because it is the effects of non-attendance, not the non-attendance itself, which should be given weight in determining disability, we cannot provide any guidance on how to weigh the non-attendance in the situation described by Chicago. Once it is determined that the absences are related to the medically determinable impairment, what needs to be determined is whether the non-attendance is causing or contributing to more-than-minimal limitations in the child's ability to function. Where the non-attendance is causing or contributing to more-than-minimal functional limitations the non-attendance-related limitations should be noted in the individualized functional assessment (IFA). If not, this should be cited in the rationale.

For additional information on the documentation and evaluation of school absences please see Childhood Disability Hotline Questions and Answers (Q & A) Transmittal No. 12, Question Nos. 4 and 5 and Transmittal No. 13, Question Nos. 7 and 8.

For a more complete discussion of parental versus physician restrictions, please see Childhood Disability Hotline Q & A Transmittal No. 13, Question No. 5.

Relationship of Number of School Absences to Function

3. Question: Is there any specific or approximate percentage of [school] absences which would be indicative of a significant impact on function due to excessive absences? (New York, 7/23/91)

Question: Is the 20% absence rate mentioned in the Instructor's Manual section D, page 4, to be used as a basis for a functional equivalency allowance? (New York, 8/19/91)

Answer:

Section D.2.d. of the Instructor's Guide discusses a "screen" proposed by the experts who helped us develop the current childhood rules. As proposed by the experts, the screen was to be a separate list of specific medical conditions or kinds of medical conditions, specific functional limitations, and other effects of impairments which would quickly identify children who were obviously disabled and who could immediately be found disabled with minimal development of the evidence. While this screen was one of the bases for the formulation of the functional equivalency policy in our childhood rules, some items, including the 20 percent absence rate screen, could not be adopted. (A complete discussion of the screen and its role in the development of the functional equivalence policy is contained in the preamble to the childhood rules published on February 11, 1991 (56 FR at 5543-5544.)

The effect of absence varies from child to child, with some children being able to miss a great deal of school without adverse effects while other children are adversely affected even if they miss much less school. Therefore, it is the effect of school absence, if such absence is related to the medically determinable impairment, on the child's ability to function that needs to be considered on a case-by-case basis. For a further discussion of this issue, see our response to Question 2. above.

Medical or Psychological Consultant Preparation of Reconsideration IFAs

4. Question: POMS DI 27015.135A indicates reconsideration level SSA-831's must be signed by an examiner and physician different from the reviewers who made the initial determination. It is assumed this requirement is also necessary in Title XVI DC claims.

Can the same physician and/or psychologist who prepared the initial IFA prepare the IFA at the reconsideration level, provided a different examiner/physician signs the reconsideraton SSA-831? (Atlanta, 7/23/91)

Answer:

No. At each adjudicative level a claimant is entitled to a new determination, and a new IFA independent of the prior IFA must be prepared. This means that a medical or psychological consultant other than the consultant who prepared the initial IFA must prepare and sign the reconsideration IFA. At the reconsideration level, as at the initial decisionmaking level, reasonable efforts should be made to ensure that a qualified pediatrician or other specialist in a field of medicine appropriate to the impairment of the child prepare the reconsideration IFA. If a qualified pediatrician or other specialist in a field of medicine appropriate to the impairment of the child other than the pediatrician or other specialist who prepared the initial IFA is not available after reasonable efforts have been made to secure his or her involvement, the reconsideration IFA should be prepared by the most appropriate source. Similarly, where there is evidence of a mental impairment(s), the assessment of the effects of the mental impairment on the child's functioning should be performed by a qualified psychologist or psychiatrist other than the medical/psychological consultant who prepared the initial IFA. (For a more complete discussion of IFA preparation and signature requirements where both mental and physical impairments are present, see Childhood Disability Hotline Q & A Transmittal No. 3, Question Nos. 6 and 9.)

As a temporary procedure to ensure that disabled children receive timely determinations in this time of increased workloads, every applicable section on the reconsideration IFA does not have to be completed in

fully favorable reconsideration level claims (as well as fully favorable determinations in initial claims) and the medical or psychological consultant may sign the IFA when, at a minimum, a summary statement reflecting the IFA is provided (see Program Operations Manual System (POMS) DI T25220.001). The summary statement must describe applicable functional limitations in the age-appropriate domains and behaviors, including those due to the effects of the other factors described in POMS DI 25220.015, supporting the favorable decision. Further, temporarily, the reconsideration level adjudicative team may adopt the IFA prepared at the initial level rather than completing an entirely duplicative form when the child's abilities and limitations in the age-appropriate domains and behaviors are found to be the same after review on reconsideration as his or her abilities and limitations in those same domains and behaviors at the initial level. If there are any changes in the functional limitations, or if the child's age at the time of the reconsideration IFA means that different domains and behaviors are being assessed, the initial level IFA cannot be adopted. (POMS DI T25220.001 is being revised to reflect this temporary procedure.)

Filing Date--CDR Readjudication Affirms Cessation but Establishes New Period of Disability

5. Question: On a CDR readjudication, if we affirm the original cessation, but find a subsequent period of disability we are to prepare both an SSA-832 for the cessation and an SSA-831 for the new period of disability. What filing date do we enter in Item 3 of the SSA-831? (Atlanta, 10/16/91)

Answer:

POMS DI 32597.010E.5.d. states, "If disability cannot be reestablished back to the month of cessation, prepare an SSA-832-U3 affirming the prior cessation and an SSA-831-U3 to reestablish disability effective with the first date from which it can be reasonably concluded that the impairment was continuously disabling." Therefore, the date of application to be shown on the SSA-831-U3 for the new period of disability should be the date of the earliest Zebley readjudication claim being reopened. The disability

determination services should input the date the subsequent period of disability is established in the date of onset field.

This is the fifteenth installment of the Childhood Disability Hotline Questions and Answers (Q & A). There are five questions organized under five topic headings in this transmittal.

Inquiries about these Q & A should be addressed to the RO Zebley Coordinators. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf at (410) 965-9245.

Growth Charts for Premature Infants

1. Question: Can we get growth charts for premature infants? (Atlanta, 3/29/91)

Answer:

Gestational age (GA) infant growth charts have been developed and are available for evaluation of growth in length, weight, and head circumference of premature infants. Growth curves that are acceptable for program purposes for the clinical assessment of infants of gestational ages up to 40 weeks have been published by Babson, S.G., and Bender, G.I., in the Journal of Pediatrics, Volume 89; pages 814-820, 1976. These charts have been adopted with permission from the authors and can be obtained through Bristol-Meyers US Pharmaceutical and Nutritional Group, Evansville, Indiana, and Ross Laboratories, Columbus, Ohio. These companies also produce growth charts for use with full-term infants. However, the growth charts for full-term infants lack the reference points for ages in weeks of gestation and are easily differentiated from the GA growth charts.

Scoring Systems for Calculation of Gestational Age

2. Question: In the Zebley training package, there is mention of special scoring systems used at birth and based on physical signs for the calculation of gestational age. Please provide information about this special scoring system. (Atlanta, 3/29/91)

Answer:

Scoring systems have been developed for calculating the GA of premature infants. The Ballard and the Dubowitz systems are both widely used and are considered acceptable for program purposes. Both systems require the scoring of several neuromuscular and physical criteria (the Ballard scoring system uses

6 neuromuscular and 7 physical maturity criteria and the Dubowitz system has 10 neuromuscular and 11 physical criteria) and both yield comparable age calculations.

IFA: Highly Structured Setting

3. Question: The sixth installment of the Childhood Disability Branch's answers to regional questions contains a Q & A about special accommodations and/or considerations (Q&A 2).

This Q&A states that when a child lives, or attends school, in a "highly structured" setting, we need to consider how the child would function without the supportive structure in order to see whether, or the extent to which, the child can function independently, appropriately, and effectively in an age-appropriate manner outside that setting.

Can "highly structured" be defined as a special education class such as a class with student/teacher rates of 15:1, 15:1:1, or 9:1:1? When a child is in special education, how do we judge how the child functions without the structure/added supervision of the special class? There does not appear to be any way to obtain the necessary information unless the child has been taken out of his or her special education class. (New York, 3/3/92)

Answer:

Program Operations Manual System DI 25220.015D.1. defines "structured or highly supportive settings" as "specially planned or designed residential or nonresidential environments in which a child is . . . placed (or lives) . . . to improve the ability to function and/or ameliorate other effects of the child's impairment(s)." A special needs classroom or school environment is an example of such a setting. Similarly, the types of special education classes cited by New York would meet this definition of highly structured or supportive settings.

The nature of the child's impairment(s) and of the support provided, how the child functions within the supportive setting and, to the extent the information is available, how the child functions outside of the supportive setting, must all be taken into consideration when performing the individualized functional assessment (IFA). It is important

to remember that the IFA should provide an explanation of the child's global functioning, i.e., his or her functioning in all areas of life--not just in school. Thus, a child's abilities and limitations of functioning in the classroom, while important, cannot be the sole basis for determining if he or she is disabled.

It is not necessary to remove the child from his or her special education class to consider how the child would function outside of the special education classroom setting. To make this evaluation, a description of the individual classroom including, but not limited to the student-teacher ratio, could be used to gauge the degree of structure or support provided to the child in particular classes. This information should be available from the school and the child's teacher(s). In addition, many children assigned to special education classes receive some lessons or instructions in non-special education classes, e.g., physical education or art. If such an arrangement exists, how the child functions in the less structured classroom settings may help. Where it is known that the child is assigned to some non-special education classes, i.e., is "mainstreamed" for some subjects, it is important to learn if this is due to the individual child's needs or simply an arrangement within the school unrelated to the child. Ideally, information about whether the child can function independently, appropriately, and effectively in the less-structured settings may be available from his or her teacher(s) in those classes. However, it is important to remember that school is only one aspect of the child's activities. Thus, while information about how a child functions in special education, and in some cases both special education and non-special education classes, may be available from the school and/or teachers, other sources who are familiar with the child outside of the special setting should be contacted where additional information is needed to make a determination as to the child's abilities and limitations. Such sources include the child's parents, caregivers, relatives, neighbors and friends.

Acceptable Medical Source Evidence of a Medically Determinable Mental Impairment--General

4. Question: If a licensed/certified psychologist or a psychiatrist establishes a diagnosis per DSM III-R based on anecdotal information and functional

description of a child's behavior, is this sufficient to establish the presence of a medically determinable impairment without formal MSE? (New York, 7/3/91)

Answer:

Regulation 416.908 provides that the existence of a medically determinable impairment must be established by medical evidence consisting of signs, symptoms and laboratory findings, not just by the claimant's statement of his or her symptoms. As presented in this question, "anecdotal information and functional description" appears to represent a narrative presented by someone other than an acceptable medical source. If this interpretation is correct, such information is not sufficient, by itself, to establish the presence of a medically determinable impairment, even when an acceptable medical source establishes a diagnosis based only on the narrative. In most cases, however, "acceptable" medical reports will reflect the medical source's own findings and observations on examination as well as his or her consideration of anecdotal information and functional descriptions provided by parents and others who are aware of the child's activities of daily living, social functioning, and ability to adapt to different settings and expectations.

Acceptable Medical Source Evidence of a Medically Determinable Mental Impairment--Attention Deficit Hyperactivity and Conduct Disorders

5. Question: Which medical specialties can provide MSE findings in a mental disorder case, e.g., Attention Deficit Hyperactivity Disorder or Conduct Disorder? Is a psychiatrist or psychologist report required? Can a pediatrician or family practicioner or other physician specialty provide MSE findings to establish this diagnosis? Are there any other acceptable sources for establishing this diagnosis (e.g., Ed. D., M.S.)? (New York, 7/3/91)

Answer:

The rules we follow do not impose any restrictions on the type of medical evidence that an acceptable medical source can provide in a claim involving a mental disorder, such as Attention Deficit Hyperactivity Disorder or Conduct Disorder. Reports from any of the

acceptable medical sources listed in regulation 416.913(a) (e.g., licensed psychiatrist, pediatrician, or other physician specialty or licensed or certified psychologist) may be used to establish a medically determinable impairment so long as the reports include the clinical findings that support the diagnosis.

The important thing to keep in mind when developing any claim is to make every reasonable effort to get reports, including clinical notes, from the claimant's own medical sources. When this and other evidence submitted are not sufficient to determine whether an individual is disabled, a consultative examination (CE) may be necessary. The rules governing the purchase of CEs (see 416.917 through 416.919t) indicate that the individual case facts will dictate whether a CE is required and, if so, whether it should be purchased from the treating source or another qualified medical source. In addition, the fifth paragraph of 112.00D in the Listing of Impairments states that in some cases when 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." However, this paragraph goes on to note that in these cases every reasonable effort must be made to obtain the records of the treating sources because they "help establish a longitudinal picture" of the child's impairment "that cannot be established through a single purchased examination."

This is the fourteenth installment of the Childhood Disability Hotline Questions and Answers (Q & A). There are 4 questions organized under three topic headings in this transmittal.

Inquiries about these Q & A should be addressed to the RO Zebley Coordinators. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf at (410) 965-9245.

Listing 109.08B--Level of Severity Required to Meet Listing

1. Question: Clarification is requested of the level of severity needed to meet listing 109.08B (Juvenile Diabetes Mellitus with episodes of hypoglycemia).

   The listing preamble (109.00A) states that disturbance or abnormalities in the secretion/metabolism of hormones must be shown to have persisted or be expected to persist (despite therapy) for at least 12 months. Where the only complication from Juvenile Diabetes Mellitus is hypoglycemia, must there be recent, recurrent episodes of hypoglycemia occurring with a longitudinal history of hypoglycemia (i.e., over a 12-month period) or does section 109.00A just refer to persistence of the hormonal disturbance? (New York, 2/27/92)

   Answer:

   If the only complication from the juvenile diabetes mellitus is hypoglycemia, there must be evidence that both the hormonal disturbance and the episodes of hypoglycemia have persisted or are expected to persist despite prescribed therapy for a continuous period of at least 12 months, consistent with the statutory duration requirement. At listing level, the severity of the hypoglycemic episodes must be of comparable severity to the level of severity in the criteria for Listing 109.08A (juvenile diabetes mellitus (as documented in 109.00C) requiring parenteral insulin with recent, recurrent hospitalizations with acidosis) and/or Listing 109.12 (hypoglycemia (as documented in 109.00C) with recent, recurrent hypoglycemic episodes producing convulsions or coma).

2. Question: Listing 109.08B permits an allowance based on recent, recurrent episodes of hypoglycemia. The listing does not indicate the level of severity of hypoglycemia intended. Would several episodes of mild hypoglycemia per week fulfill this listing? For cases which are clearly not

at listing level, are there any significant areas that should be considered in making an IFA assessment? (New York, 2/27/92)

Answer:

It is not so much the frequency of the hypoglycemic episodes as their severity which determines listing level for purposes of fulfilling the requirements of Listing 109.08B. As explained in our response to Question No. 1 above, the level of severity of the hypoglycemic episodes described in Listing 109.08B must be comparable to that required by the criteria in Listings 109.08A and 109.12. Where the hypoglycemic episodes are frequent but of lesser severity, listing-level severity would not be met despite the frequency of occurrence.

At the individualized functional assessment (IFA) step of the sequential evaluation, consideration would have to be given to the extent to which the hypoglycemic episodes affect the various domains and behaviors. Mild, recurrent hypoglycemic episodes which occur frequently, such as three to five or more times a day, could affect development or function in the cognitive, communicative or motor domains, or concentration, persistence and pace and could possibly affect social and behavioral functioning. As always, each case will have to be evaluated on its own merits.

Documentation of Physical Impairment--Evidence Sufficient to Allow on Basis of Mental Impairment

3. Question: In cases involving both mental and physical impairments, in which the evidence of the mental impairment is itself enough to establish disability, do we have to develop evidence of the physical impairment as well? Do we have to address the evidence relating to the physical impairment in our IFAs or final determinations? (On-Site Visit)

Answer:

Once the file is sufficiently documented to support a finding of disability, additional development can be curtailed. Therefore, in the situation presented, continuing to develop evidence of the physical impairment would not be necessary. Since the evidence relating to the physical impairment is not material to

the decision, it need not be discussed in any required rationale or IFA. However, the rationale or IFA, if required, should acknowledge the allegations made, mentioning any other impairment(s) alleged and the fact that they are not material to the decision.

Evidence relating to the physical impairment may be needed when a continuing disability review (CDR) is conducted. If, at the time of the CDR, the claimant's impairment(s) does not meet or equal in severity a current listing, a determination will be needed as to whether there has been medical improvement (MI) in the impairment(s) present and documented at the time of the most recent favorable determination. If, at that time, the file contained evidence showing the existence of the physical impairment, then current evidence related to the physical impairment will be needed in order to determine whether MI has occurred. For more detail on how to determine which impairments to consider in deciding whether MI has occurred, see Program Operations Manual System (POMS) DI 28010.010.

Evaluation of Non-English Speaking Children

4. Question: How are we to evaluate children who cannot speak English? We have an example of a three year old child who has been diagnosed with some minor physical impairments. The child is being raised by Vietnamese parents. The child's pediatrician reported no problems in the child's ability to speak. In addition, the child has no problem with receptive speech. It is our opinion that this is a cultural situation and in no way related to a medically determinable impairment. Therefore, we suggested to the DDS there would be no limitation of function for this particular child because he does not speak English. However, we would appreciate your comments on how these cases should be evaluated for children of different ages. For instance, if this child was 9 years old one could argue that he would be limited in his school activities since he would not be able to understand his teacher, fellow pupils, etc. How would we evaluate older children, i.e., 16-18, since we are told it is important to consider functional restrictions in this age group that apply to the ability to do basic work related functions. (Dallas, 3/28/91)

Answer:

A child who cannot speak or understand English because of a lack of exposure to the language, but who speaks and understands the language of his or her parents or caregivers, does not have a medically determinable communicative impairment. It is not unusual for a 3-year-old child to have limited social contacts outside the sphere of his or her family or neighborhood. While the question indicates the child has no problems with "receptive speech," the phrase "receptive speech" inappropriately combines two aspects of communication, speech (i.e., the production of meaningful sound) and language (either expressive or receptive). Therefore, we are assuming that what is meant is that the child has no problems with receptive language, i.e., comprehension.) The determination of whether a given child has a communicative impairment is made after examination of all of the evidence in the child's case. In this situation, we have been provided with minimal information about a 3-year-old child. Assuming this information accurately reflects the facts in the case, it appears this 3-year-old's inability to speak English is related to his cultural situation rather than to any medically determinable impairment and that, therefore, no communicative limitation should be cited in the evaluation of the child.

The ability to speak, read and understand English is generally learned or increased at school. Given that, a younger school-age child, initially limited in his or her school activities because of an inability to speak, read or understand English due to a lack of exposure to the language, should see these limitations diminish as he or she progresses through school and becomes more proficient in the English language.

Obviously, if there is an allegation that the child is experiencing difficulty learning English, whether the allegation is raised by the applicant or by the medical or other evidence in the file, it has to be addressed in the development of the case. If the difficulty can be attributed to a medically determinable physical or mental impairment, the functional limitations imposed by the inability to speak, read, or understand English should be considered when determining if the child has an impairment which substantially reduces his or her ability to function independently, appropriately, and effectively in an age-appropriate manner.

Age-appropriate activities for older adolescents, age 16 to the attainment of age 18, are the same as, or similar to, those work-related physical and mental activities appropriate to the youngest adults, age 18 to 45. The decision made on the claim of a 16 to 18-year-old must be consistent with the decision made for an 18-year-old having the same impairment-related functional limitations. To be found disabled, an older adolescent must be unable to perform either the basic physical activities of at least sedentary work or the basic mental activities of at least unskilled work. However, the inability to communicate in English should have no effect on the individual's ability to perform at least unskilled work. This is consistent with the decisions made for 18-year-olds under regulation section 201(h) and Rule 201.23.)

This is the thirteenth installment of the Childhood Disability Hotline Questions and Answers (Q & A). There are 12 questions organized under 9 topic headings in this transmittal.

Inquiries about these Q & A should be addressed to the RO Zebley Coordinators. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf at (410) 965-9245.

Interrelationship of Symptoms and Environment

1. Question: In the case of [SANITIZED], the treating source states that symptoms are related to lack of environmental control. Assuming that the frequency/severity of asthma attacks would warrant an allowance, how should the DDS address this issue? Would it be appropriate to pursue failure to follow prescribed treatment? (New York, 8/19/91)

   Answer:

   If the asthma is disabling, and the treating physician prescribed changes in the child's environment as treatment for the child's asthma, and such changes would be clearly expected to restore the child's ability to engage in age-appropriate activities, the disability determination services (DDS) should follow the full failure to follow prescribed treatment procedures in Program Operations Manual System (POMS) DI 23010.010. This will require the DDS to determine if there has been a refusal to follow the prescribed treatment, and there is no good cause for the refusal. If the environmental changes are not prescribed as treatment, failure to follow prescribed treatment is not an issue, and the assessment of the child's functioning should be based on how the child functions in the environment in which he or she lives.

Evaluating Reported Behavior

2. Question: After evaluating a large number of childhood claims, one glaring issue keeps emerging, namely, behavioral reports from the school and the home which vary. The advice usually offered at this point [is] to request additional information to resolve the conflict.

   It is an empirical fact that children as well as adults display different behaviors in different settings. It is not unusual at all that a child may behave

differently at home than in school. There is nothing to be resolved since the differences in behavior are consistent with what we know about how people function.

[A child may] . . . behave appropriately when visiting a museum or going to the theatre and [inappropriately] . . . in other settings. . . . Please comment on these issues. (Kansas City, 8/16/91)

Answer:

We agree that differing behaviors in different contexts do not necessarily represent a conflict. However, differing reports of behavior in the same setting do represent a conflict. The evaluation of a child's behavior involves consideration of many factors including, but not limited to:

- The age of the child
- The nature of the impairment
- The nature, intensity, frequency, and history of the behavior(s) in question
- The degree of structure in the home and school settings
- The type of classroom placement, i.e., special education, regular classroom, or a combination of both
- The size of the class
- The types of special accommodations made at home or at school, if any
- The history of any intervention to change the child's behavior, and results of such intervention
- The ability of the source to provide accurate and objective observations

If a child behaves differently in different settings, the DDS must make a global assessment of the child's ability to function in an age-appropriate manner. This decision must be made on a case-by-case basis, considering all the factors mentioned above along with any other relevant factors, and keeping in mind that we cannot always give greater weight to behavior at school. For example, a child in a highly structured special education class may not be able to function in an age-appropriate manner if that degree of structure is removed. Likewise, a report that a child is functioning well compared to other behaviorally impaired children in a special education class, but without specific descriptions of the child's actual behaviors, is not very valuable in determining how the child compares to a "normal" child. In these types of

cases, the behavior at home may give a truer picture of the child's overall ability to function. Conversely, if the home environment is particularly stressful or unsupportive, behavior at school may provide a truer picture. In any event, the individualized functional assessment (IFA) and/or rationale should explain how the evidence was weighted and evaluated.

There are also cases with true conflicts in the evidence--i.e., the parent and teacher provide different descriptions of how the child behaves in the same setting. Such conflicts need to be resolved if they are material to the disability determination. Additional development may be needed; in many cases, a phone call to one or both conflicting sources to pin down specifics about the child's behavior may be all that's needed to resolve the issue.

To determine "comparable severity," we determine if the child's impairment causes a substantial reduction in the child's ability to function independently, appropriately, and effectively in an age-appropriate manner; i.e., how the child's functioning compares with that of unimpaired children of the same age.

Even for older adolescents, for whom age-appropriate activities do include work-related functions, we do not always give greater weight to behavior at school. School records may well provide solid information on a child's ability to perform those sorts of activities but, as noted above, performance in a highly-structured school environment might not provide a true picture of how the child would be able to perform work-related functions in the real world.

3. Question: Is it necessary to obtain a mental status examination in every case in which a parent alleges that a child is a "behavior problem"? If not, can you give us any guidance on what is within the normal limits of behavior? For instance, would we need a mental status examination in the case of a 13-year-old girl whose mother says she is a behavior problem because she is defiant and unpleasant to her parents, who has been arrested once for shoplifting, and has been suspended from school once for name-calling? Suppose we also had evidence from teachers indicating no other behavioral problems? (New York On-Site Visit, 9/23-24/91)

Answer:

Behaviors, such as fighting, lying, and not paying attention in class are not always indicative of a mental impairment. It is important to remember that we are comparing the child for whom the claim is filed to a "normal" child, not a "perfect" child, and that normal children may have behavior problems at times. For example, it is not unusual for adolescents to be defiant towards parents and other authority figures or to exhibit occasional unexplained mood swings.

In cases where behavior problems are alleged, the DDS should determine the nature of the behaviors (e.g., whether the fighting is verbal or physical), the frequency with which they occur, their intensity, the settings in which they occur (e.g., whether they occur only in the home or only with the parent), the precipitating events, measures taken to correct the behaviors, and the response to those measures. If the behavior problems are those which would be exhibited by a "normal" child, or if they result in only slight or minimal limitations in the child's ability to function, a mental status examination is not required. These are clinical judgments which must be made considering all the facts in the case, such as the child's school placement, statements about the child's behavior from parents and school personnel, any history of disciplinary actions, school suspensions, or involvement with the court system.

Regardless of whether or not a mental status examination is required, the behaviors must be acknowledged and the clinical judgments made about their effect on the child's ability to function must be explained in the rationale and IFA.

Evaluation of Problems in Articulation

4. Question: We are having difficulty in determining whether some children with apparent articulation problems have true "medical" impairments. Specifically, we are concerned about situations in which the child's parents have speech problems and it is not clear whether the child's articulation is merely something that was learned in the home. Can you provide any guidance? (Atlanta On-Site Visit, 10/22-23/91)

Answer:

We assume that the question is posed in the context of a child who is alleged to be disabled by a speech problem, either alone or in conjunction with another impairment(s). In such an instance, no assumption should be made that a child's articulation problem is imitative merely because the child's parents also have articulation problems.

If an acceptable medical source (e.g., pediatrician, otolaryngologist, neurologist) indicates that a child has a speech impairment, evaluation by a licensed or certified speech pathologist may be needed to determine the severity of impairment. A speech pathologist would consider many factors, including the child's age, since misarticulation by young children is frequently a part of speech development, and the child's speech patterns. Speech pathologists are trained to make expert observations and to administer tests that enable them to discern whether a child's articulation problems are imitative (parochial) or the result of speech deficits.

If the child's misarticulation has been identified as a problem by the school system, the parent, or any other individual, the file should be documented to show what, if any, interventions have been instituted and the child's response to these interventions. If information from all medical, professional, and lay sources confirms that the child's misarticulation is solely imitative or otherwise not impairment-related, the misarticulation would not constitute a medically determinable impairment.

Parental Restrictions vs. Physician Restrictions

5. Question: We understand that limitations in functioning should be based on a medically determinable impairment. How much weight should be placed on parental restrictions (the overprotective parent) versus medical (physician) restrictions? (Philadelphia, 3/28/91)

Answer:

When we determine whether a child is disabled, we evaluate the child's complete functional profile in terms of the age-appropriate activities the child

actually can and cannot do. When we create this profile we will also have to consider any opinions or judgments about things a child should not do because of his or her medically determinable impairment(s) even though the child might, technically, be "able" to do them. If there are preventive restrictions imposed upon the child that limit the child's functioning, it is necessary to make a judgment about the basis for the restrictions; that is, whether they are based on physician knowledge or parental experience, or on parental concern about the possibility of harmful consequences.

It is possible that both physician and parental restrictions may be related to medical prohibitions. For example, a child with an arteriovenous malformation in the brain may be asymptomatic but may still have to avoid certain activities because there is a real risk of serious consequences; or an adolescent with an average of one major motor seizure every 2 months may be medically prohibited from getting a learner's permit to drive a car; or a child with asthma may be told by his or her parents not to play sports because, despite proper treatment, the child's condition exacerbates when he or she exerts him or herself at a level needed to play sports.

Parental restrictions should not be dismissed merely because they are not mentioned by a physician. If the parent's restrictions are reasonable given the child's impairment and his or her overall medical picture, no further development is necessary. However, where the parental restrictions seem unusual, additional development will be necessary to determine whether the parental restrictions are based on a physician's advice, or the parent's or caregiver's own experience in caring for the child, or the parent's or caregiver's personal concern for the child. If a physician has recommended the restrictions, the DDS should contact the doctor to confirm the advice given the parent or caregiver. If the parent or caregiver has imposed the restrictions, ascertain whether the restrictions are based on past experience or on general concern for the child. If restrictions are based on past experience, ask for descriptions of those experiences and, if appropriate, confirm with the treating physician the frequency and seriousness of the events described. If the parent or caregiver indicates that the restrictions are based on concern for the child's well-being and the possibility of harmful consequences, rather than on the parent's or caregiver's past experience in caring for

the child, contact the treating source to ascertain if the parent's or caregiver's restrictions are warranted based on the medically determinable impairment(s).

Remember that your finding of disability is based on a legal standard and that we do not second-guess a child's physician or parents. It is important, then, that adjudicators consider the basis for the restriction(s) on the child's activities in order to assess the significance of the physician or parental restrictions in the child's functional profile. It also should go without saying, however, that limitations on a child's activities imposed by a treating source reflect treating source opinions that are entitled to extra weight and that may be controlling in some circumstances. (See regulation § 416.927(d)(2) and POMS DI 24515.002 and DI 24515.003.) If your findings do not adopt the treating source's opinions about the extent of a child's limitations, it is imperative that your rationale explain why.

School Evidence--Home Schooling Where Parent Is Also Teacher

6. Question: The new rules place an emphasis on obtaining evidence from both parents and teachers. Could you please comment on the situation in which the child is schooled at home, so that the child's parent is also the child's teacher? (Atlanta On-Site Visit, 10/22-23/91; Chicago On-Site Visit, 8/5-7/91)

Answer:

The number and types of sources to contact in cases involving home schooling must be determined on a case-by-case basis. In cases where the parent is also the teacher, the parent should be asked for the same type of information normally requested from a teacher. If the parent cannot supply sufficient information or if there are conflicts in the file, the parent should be asked if there are other sources who would have the relevant information. These sources could include, but are not necessarily limited to, other relatives, neighbors, or adults involved with the child in extracurricular activities such as sports or scouting. Additionally, if the state monitors the child's progress by administering standardized testing, the results of this testing should be available and every reasonable effort should be made to obtain it.

School Absences--Relationship to Severity of Impairment

7. Question: Guidance is needed on the proper documentation and evaluation that is appropriate in order to address the issue of school absences in child cases.

How should we handle cases where, for example, a child's mother says the child is absent due to asthma and school records show absences attributed to asthma but the child did not require emergency room or treating physician care accountable for the absences? Can we dismiss such absences as not attributable to a medically determinable severe impairment since, by definition, a severe asthma attack would require treatment by a medical source? (New York, 7/23/91)

Answer:

Before answering the question, we must distinguish between the definition of severe attacks of episodic asthma given in section 3.00C of the respiratory listings and the definition of what constitutes a severe impairment for purposes of step 2 of the sequential evaluation for children. For purposes of meeting a particular listing, the description in 3.00C ("prolonged episodes . . . requiring intensive treatment . . .") may be applicable. However, for purposes of determining whether a child has a severe impairment, the term "severe" means the impairment or combination of impairments imposes more than slight or minimal limitations on the child's ability to engage independently, appropriately, and effectively in age-appropriate activities. Thus, an impairment(s) that imposes more than slight or minimal limitations is, by definition in our regulations, severe--whether or not a particular manifestation, such as an asthma attack, requires treatment by a medical source.

In order to consider the effect of school absences on the child's ability to function, the absences have to be related to a medically determinable impairment(s). A determination of whether the impairment(s) is severe cannot be made without considering the effect of the school absences. Therefore, if the child is frequently absent from school due to asthma, the fact that the asthma attacks are not serious enough to require emergency room or treating physician care would not

preclude us from considering the effect(s) of the absences in evaluating the severity of the impairment and, where the impairment is severe, in evaluating the effects of the impairment on functioning in assessing equivalency and in performing the IFA.

School Absences-Consideration in the Childhood Sequential Evaluation Process

8. Question: Should school absences be evaluated in the context of the IFA rather than under functional equivalency? (New York, 8/19/91)

Answer:

The effects of school absences must be considered at any step of the sequential process where the child's ability to function is assessed, i.e., in determining whether the impairment is severe, in determining equivalency, and at the IFA step of the sequential evaluation process.

Readjudication Cases--No Current Medical Evidence

9. Question: We need further guidance on how to process readjudication cases. The following example illustrates our questions. The DDS received a readjudication case with an application in 1984 when the child was 14. They requested evidence from sources from 1984 and received a WISC-R which revealed valid IQ scores in the low 60's. The case can be reopened back to the 1984 application using this WISC-R. This child is now 21 and has no current treatment sources listed. Is the DDS supposed to arrange a consultative examination to obtain current IQ tests since the WISC-R was administered prior to age 16? The POMS section is written to explain the presumption but it assumes current evidence will be available and the DDS can presume disability back to the earliest application. We are seeing several cases in which evidence back to the earliest application is received in the DDS but no current evidence is available. If no current medical evidence is available should the DDS arrange CEs to determine current severity, or, if there is no indication of improvement should the case be allowed on the old evidence without a current CE? (Dallas, 12/18/91)

Question: Readjudication cases, claimant is in 20's and currently working. No current impairments alleged, no current medical sources. Once DDS has obtained past MER, is it necessary to obtain a CE [to] determine if the claimant is currently disabled? (Atlanta, 10/15/91)

Question: We seek Central Office guidance on development and adjudication procedures for processing Zebley Readjudications in which the claimant provides no current MER sources and current non-medical evidence does not establish significant limitations in functioning. Can you provide guidelines on acceptable parameters for adjudicating a readjudication case with old medical evidence and current non-medical evidence? (Atlanta, 1/6/92)

Answer:

POMS DI 32597.010C.3. states that development of existing medical evidence of record is necessary back to the earliest relevant application even if it involves intervening periods of substantial gainful activity. Normal case development procedures and consultative examination (CE) development guidelines in POMS DI 22501.001ff. and DI 22510.001 are applicable. Per POMS DI 32597.010D.1., the DDS should assess the evidence to determine if disability can be established for the entire reopened period. The presumption can be applied if the individual is currently disabled and there is no contrary evidence or medical judgment to rebut the presumption. Since there is no evidence in file to establish current disability, current evidence must be developed by purchasing a CE.

Pipeline Cases--Citation of Sources of Medical Evidence of Record

10. Question: In pipeline cases, how do we list, or do we list, all sources of MER from previous decisions, i.e., a decision superseded by an allowance? (West Virginia On-Site Visit, 10/3-9/91

Answer:

POMS DI 25225.001C. contains a general discussion on the citing of sources. The importance of citing sources is to document the case record so that the

claimant and any subsequent reviewer can clearly tell what evidence was used to make a decision. Since the pipeline determination will have necessarily considered the existing medical evidence used in making the interim standard determination, that evidence must be cited. The sources may be listed again or may be incorporated by reference if the prior decision lists them and the information is in the current file.

This is the twelfth installment of the Childhood Disability Hotline Questions and Answers (Q & A). There are 15 questions organized under 13 topic headings in this transmittal.

Inquiries about these Q & A should be addressed to the RO Zebley Coordinators. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf at (410) 965-9245.

Evaluating Obesity in Children

1. Question: Could you provide some guidance for evaluating obesity in children? May we use the tables in adult Listing 10.10 to find that a child meets? Since expected normal weights for children are generally lower than they are for adults, is it possible to determine whether a child of a given age is 100% above the desired level for his or her age and height in order to make an equivalency determination, even though that weight will likely be less than what is shown in the adult tables? If the child's impairment does not meet or medically equal a listing, how can we consider obesity when deciding functional equivalence or disability at the IFA step? (Chicago On-Site Visit, 08/5-7/91; Atlanta On-Site Visit, 10/22-23/91)

   Answer:

   When evaluating obesity in children use the adult Listing 10.10 as a reference listing. As Atlanta points out, Tables I and II of Listing 10.10 set forth criteria for listing-level severity for adults. Therefore, when evaluating obesity in children, in place of Tables I and II, use the National Center for Health Statistics (NCHS) height and weight charts appropriate to the age and sex of the child being evaluated as a reference for normal heights and weights. Use of the NCHS charts, which are available for boys and girls in all age groups up to age 18, will allow adjudicators to identify listing-level severity, i.e., whether a boy or girl is 100 percent above the desired weight level for his or her age and height, for children. These charts may also be used with the temporary procedures in Program Operations Manual Systems (POMS) DI T24515.001D.10. As with adults, evidence that the child meets the stated weight requirement is not a basis, by itself, for allowance; it is possible for a child to be 100 percent above the desired weight level for his or her age and height and still not be disabled.

Since there is no obesity listing for children, a child may be found to have an impairment that medically equals the adult listing for obesity if his or her weight is 100 percent over the weight shown in the age-appropriate charts described above and the child has one of the associated required criteria in Listing 10.10. As with adults, it is not necessary to quantify or qualify the impairment beyond the degree or extent reflected in the respective criteria (see POMS DI 24515.030).

Where a child's obesity leads to a dysfunction(s) other than those specifically cited in the listing, a finding of equivalence may still be appropriate. For example, an extremely obese child may not demonstrate any of the medical findings specifically noted in the listing, but may have other manifestations, such as chronic skin problems caused by constant friction secondary to the obesity. If the skin problems are sufficiently restrictive, a finding of medical equivalence to Listing 10.10 may be appropriate. Or, the child's extreme obesity may result in restrictions in activities of daily living (ADL) to the extent that he or she is unable to dress or bathe without assistance, or to participate in normal classroom and play activities or use conventional transportation. If the obesity limits the child's ADL to an extent comparable to the paragraph "B" criteria in the childhood mental listings, a finding of functional equivalence may be appropriate (DI 25215D.2.c.).

Where listing-level severity cannot be established, evaluation would continue through the preparation of an individualized functional assessment (IFA). At this step in the sequential evaluation process, all of the relevant information that can help us to determine the impact of the child's impairment(s) on his or her physical and mental functioning is considered. Relevant information may include medical and nonmedical evidence (e.g., school records, information from caregivers, parents, and others), and must take into consideration all of the child's impairments. For example, in assessing the child's functioning in the motor domain, consideration should be given not only to any physical limitations noted, such as "cannot ride a bike" or "cannot climb stairs," but also to any limitations in pace, i.e., limitations in the ability to sustain an activity, such as "shortness of breath after walking a short distance" or "is unable to run because of restrictions imposed by the obesity." Extreme obesity may also affect the child in the social and personal/behavioral domains. For example, the child may become reclusive, not interacting appropriately with his or her peers (social domain) or have difficulty dressing, bathing, or grooming him or herself without parental assistance which is inappropriate for age (personal/behavioral domain).

On the basis of the IFA, a determination can be made whether the child's impairment-related limitations and restrictions preclude age-appropriate functioning.

Listing 112.09A2

2. Question: Under A2 of Listing 112.09, must the attempt to cut down or control use be in a formal treatment program? (Atlanta, 12/20/90)

Answer:

No. An individual's attempt to cut down or control use of a substance may occur apart from a formal treatment program. Therefore, the paragraph A2 criterion of Listing 112.09 is not dependent upon where the individual's attempt to cut down or control use of the substance occurs. For example, in situations where the individual has no treating source and has not participated in any treatment programs, documentation of the paragraph A2 criterion may be provided by a consultative examiner based on information the individual furnished during the examination.

Two important things should be remembered when examining claims involving allegations of a psychoactive substance dependence disorder. First, the paragraph A2 criterion and the other paragraph A criteria in Listing 112.09 are used only to substantiate the existence of the disorder while impairment severity is judged based upon the functional impact of the disorder (the criteria in 112.09B). Second, a single criterion alone does not confirm the existence of a psychoactive substance dependence disorder. The capsule definition of the listing requires "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." Listing 112.09A requires medically documented findings of at least four of the six criteria in paragraph A to satisfy the requirements of the listing.

Completion of the IFA--Part C

3. Question: Describe how Part C of the Individualized Functional Assessment should be completed. Should severity be addressed in this section? (Chicago, 11/1/91)

Answer:

Although "Other Factors" is shown as a separate section on the IFA form, these factors are not independent of the domains and behaviors. Therefore, it is not appropriate to rate the severity of any of the applicable factors when completing part C. The factors are shown on the IFA both as a reminder that they must be considered and as a way of documenting the file to show that they have been considered. They should be considered not just in evaluating the domains and behaviors when performing the IFA, but throughout the evaluation process. If any of these "other factors" apply, the adjudicator should check the appropriate block(s) and provide a brief explanation of the impact of the factor(s) on the case.

By way of example, assume the case file reflects the following information:

1. The child is in a special education class for children with behavioral problems;

2. The special education teacher reports the child does not exhibit significant behavioral problems in the class but indicates that an aide works with the child on a one-to-one basis for the entire time the child is in class;

3. The parent reports self-destructive behaviors at home;

4. The child is no longer allowed on the school bus because of throwing things at passing cars;

5. The child has an impairment which causes the behavior problems.

Given these facts, it would be reasonable to conclude that:

1. The child is able to function in the special education classroom because of the high degree of structure provided;

2. The behavior outside the classroom is more reflective of the child's ability to function in a "normal" setting; and

3. Greater weight should be given to the behavior outside the classroom setting when evaluating the severity of the limitation in the personal/behavioral domain.

To document this on an IFA, the adjudicator would complete part C by checking the block for structured settings and by entering the above conclusion as an explanation of how this factor affected the evaluation of the domains and behaviors. Then, as indicated above, the adjudicator should incorporate the effects of the "other factors" in rating the individual domains and behaviors as to severity.

Documentation of School Absences

4. Question: Must all [school] absences be documented in terms of relationship to an impairment? What evidence is needed to establish that the absences are related to an impairment? Is a school official's or teacher's statement sufficient? Must attendance be documented in cases where there is no allegation of absences related to an impairment? (New York, 8/19/91)

Question: Must we have a statement from a medical source that confirms that the [school] absences were due to a medically determinable impairment? If medical confirmation is needed, will school medical records suffice if they show that the absences are attributable to a medical condition? Or will confirmation from a treating source be needed? (New York, 7/23/91)

Answer:

Where a child's absences from school are related to his or her impairment(s), the effects of the absences should be considered in evaluating overall functioning in determining severity, functional equivalence and in the IFA. However, it would be unrealistic to expect that all school absences be related to the child's impairment(s). As always, a case-by-case assessment must be made to determine the degree to which any school absences are related to the impairment(s).

School absences need only be documented when there is an allegation or evidence (e.g., report card) of frequent absences caused by the impairment(s) and these absences result in more than minimal limitations in the child's ability to function in an age-appropriate manner. The evidence required to verify that the child's school absences are related to his or her impairment(s) will vary from case to case. Medical evidence in file may already show dates on which the child received treatment. If the school absences match those dates, no further development is necessary. If there are additional absences, and the nature of the impairment is such that the number of additional absences is reasonable, the absences can be presumed to be due to the impairment and no further development would be needed.

However, where there are absences that do not correspond to treatment dates and these absences cannot be presumed to be caused by the impairment, the applicant should be contacted and asked to explain the reason for the absences. If the absences were due to exacerbations of the impairment(s), ask the applicant to describe the child's symptoms, how the child was treated (if at all), and how long it took the child to respond. If the absences were preventive, determine if the applicant was acting on a doctor's advice or based on past experience. If on a doctor's advice, the disability determination services (DDS) should contact the treating physician to confirm what the applicant was told. If the applicant kept the child home due to past experience, have the applicant describe the past experience(s). If the past experience(s) involved situations where the child was sent home from school, confirmation from the school should be obtained.

5. Question: What evidence is needed to document school absence? Would a report card showing absences or a teacher's statement suffice? (New York, 8/19/91)

Answer:

If it is necessary to document school absences, i.e., the absences, which are related to the child's impairment, result in more than minimal limitations in the child's ability to function in an age-appropriate manner, the file should show the actual number of days the child was absent, or as specific an estimate as possible. It should be noted that absences include

times the child was tardy or had to leave early. Statements such as "the child missed many days of school" are not sufficient. The applicant's allegation as to the number of absences does not need to be verified if the absences correspond with dates of treatment or the nature of the impairment is such that the number of absences is reasonable and/or the absences correlate well with information received from the child's school. Otherwise, the child's report card or a statement from the school should be requested to verify the number of absences.

Diaries--Premature Infants

6. Question: In establishing a diary for disabled premature infants, it was indicated in the train-the-trainer session that you should not diary for less than 6 months. Most DDSs are diarying for 1 year but using a variety of beginning times for this year. Would it be 1 year from the date of adjudication, the date of birth, or in the case of a premature baby, the date it should have been born? (Kansas City, 3/26/91)

Answer:

In a child's case, a medical improvement expected (MIE) diary is set for a time when the child is expected to demonstrate medical improvement (MI) related to the ability to perform age-appropriate activities and to be able to perform such age-appropriate activities independently, appropriately and effectively. POMS DI 25225.005 instructs the adjudicator to set a MIE diary in cases where a premature infant meets the criteria for functional equivalence up to one year of age in DI 25215.015B., Examples 10 or 11. Because these children are deemed to be disabled from birth through at least the attainment of a chronological age (CA) of 1 year (thereby meeting the 12-month duration requirement), the MIE diary cannot be set earlier than the child's first birthday. Further, as a general rule, a MIE diary should not be set for less than six months from the month of the current determination as sufficient time must elapse from the date of the current decision to allow the expected improvement to occur. As previously indicated in Childhood Disability Hotline Questions and Answers (Q & A) No. 1, Question 5, dated April 8, 1991, there should be no correction for prematurity when setting diary dates.

Premature infants, even those who do not meet the functional equivalence examples in DI 25215.015B., can be developmentally delayed for some time following their birth. When setting a diary date, both the severity of a child's impairment and his or her age at the time of adjudication must be considered. As a general rule, the child's prematurity and its impact on his or her development become increasingly less significant as the child reaches age 2. Thus, while each case must be evaluated on its own merits, generally MIE diaries for premature infants should not extend beyond the month the child attains a CA of 2.

If the claim is filed before age 1 but adjudicated after age 1, a closed period can be established if the child no longer meets or equals a current listing, has demonstrated MI related to the ability to work (as defined for children), and no longer has a disabling impairment. The ending date would be any month after the attainment of age 1 in which all the criteria for a cessation are met.

Need for Technical Rationales--Fully Favorable A66 Allowances

7. Question: DI 252, TN 1 - DI 25225.001 C. has been revised to reflect that the rationale may incorporate information from the personalized denial notice by reference and that a separate rationale is not necessary IF (emphasis added) the IFA and the IFA and the PDN together, cover ALL the required elements of the rationale including the citation of the medical and non-medical evidence. We would like to propose that the Zebley process be further streamlined by eliminating the need for technical rationales on fully favorable A66 allowances. To do so would result in a considerable time and resource savings for DDSs without compromising the quality of the decision for the claimant. If the purpose of the rationales in these situations was to gain information about the application of these new reg. basis codes, it would seem after approximately a year of experience with their use, any problems with their application should have been resolved.

Again, we would appreciate consideration of these issues. (Atlanta, 3/3/92)

Answer:

We appreciate Atlanta's interest in seeking ways to conserve DDS time and resources. However, as we indicated in our response to Question 4, Childhood Disability Hotline Q & A Transmittal No. 6, issued December 12, 1991, the primary reason a rationale is required in cases adjudicated at the functional equals step is to enable an independent reviewer to be able to tell from the case record how the adjudicator arrived at the conclusion that a child's impairment functionally equals the severity of a listed impairment. (For the same reasons, a rationale is also required for decisions made at the "not severe" and "comparable severity" steps of the childhood sequence.)

Although adjudicators have gained considerable experience in applying the current childhood disability rules, it is still important to ensure that the case record adequately reflects the basis for the decision. Thus, we will continue to require explanations of the decisions in these cases.

Rationales Not Required

8. Question: DI 25225.001 B.1. instructs the DDS to prepare rationales for denials at either the severity step (N44-924) or the comparable severity step (N40-924). Are rationales required when a case is denied using the following regulation basis codes? N36-916; N37-918; N38-916; N39-930? (Dallas, 12/18/91)

Answer:

Decisional rationales, as described in POMS DI 26515.001ff., are not required for denials based on insufficient evidence (N36-916), failure or refusal to submit to a consultative examination (N37-918), the claimant not wishing to pursue the claim (N38-916), or failure to follow prescribed treatment (N39-930). However, the file must clearly explain the basis for the denial and, where appropriate, must clearly show the efforts that were made to obtain the claimant's cooperation and/or the evidence required.

Personalized Denial Notices--Child Under Age 18 at Filing/Age 18 or Over at Time of Adjudication

9. Question: For cases where the child is under age 18 at filing but age 18 or over at time of adjudication, and a PDN is needed, how should the different criteria be addressed in the PDN, especially where the impairment is severe and IFA/RFC forms are needed? Should both the issue of comparability to adults and the RFC be addressed in the PDN? (New York, 4/18/91)

Answer:

In situations where a title XVI disabled child claimant attains age 18 during the adjudication of his or her claim, and a denial of the claim is appropriate, the personalized denial notice (PDN) should discuss both the childhood and the adult criteria.

POMS DI 26530.020 describes the elements of a PDN. The fourth element addresses the allegations raised by the claimant. When preparing this section of the notice for the situation described by New York, it is preferable to use language such as "You said you were disabled because . . . ." rather than "You said you were unable to work because . . . ." or "You said you were unable to engage in age-appropriate activities because . . . ."

The fifth element of the PDN is a discussion of the evidence in file. Following this discussion, the notice should contain a statement that indicates the claimant is not substantially reduced in his or her ability to independently, appropriately, and effectively engage in age-appropriate activities. After this, the vocational aspects of the denial (elements 6 and 7) should be addressed.

Requesting Prior Folders in Zebley Closed Period Allowances

10. Question: [This] question deals with the need to recall prior folders when we are going to do a closed period allowance. DI 32597.010 D.3. states that when current disability cannot be established, or presumptions for the earlier period cannot be applied, request the prior Zebley claims. DI 32597.020 A.1. states that the DDS will request prior Zebley folders only if a denial/affirmation of a prior termination

appears warranted or if unable to establish disability as of the earliest Zebley application date. Neither reference specifically addresses the need to request prior folders when a closed period is to be established. We would like to propose that when a closed period with an onset as of the earliest filing and an ending date after the date of the latest Zebley application date, it would serve little purpose to obtain prior files dealing with an earlier period. If we have sufficient evidence after the latest filing, the earlier files would contain nothing that would address the issue of the ending date of disability. To request prior folders in this circumstance would serve only to delay paying the claimant. (Atlanta, 1/6/92)

Answer:

Under existing instructions, you do not have to request prior folders. In the circumstances described by Atlanta, you would have already established disability as of the earliest filing date and the prior files would not contain any information relating to the later period of time. Thus, it would not be necessary to secure the prior folder to render this type of closed period determination. The references cited would only be applicable in situations where a fully favorable determination could not be rendered in the retroactive period and the prior folder(s) might contain information to render a determination for the period in question.

Development of Medical Evidence in Zebley Cessations

11. Question: We are requesting policy on processing Zebley redetermination cases that have received cessations in the Zebley timeframe. In DI 32597.010 E1 the instructions advise us to reopen the case from the earliest date of cessation to the present. The POMS then refers you back to DI 32597.010C.3. for case development. This section advises the examiner to develop MER back to the earliest relevant application.

Our policy question is, do we develop a Zebley retro cessation from the earliest cessation date or from the application date of the comparison point decision? (Atlanta, 11/5/91)

Answer:

In the situation described, the case is being reopened from the earliest date of cessation. However, in order to make a comparison, evidence would be necessary from the most recent prior medical decision that found the individual disabled. In some cases this might be a continuance decision, but in most cases it would be the application date of the original allowance decision.

Zebley Readjudication Cases-Evidentiary Requirements When Presumption Not Applicable

12. Question: In readjudication cases in which we decide that the presumption cannot apply but that we must try to obtain evidence as far back as the date of the application, how much effort are we required to make to develop this evidence? Is the rule "every reasonable effort," as for current claims, or are there special efforts we still need to make? We are especially concerned about school evidence and other kinds of nonmedical evidence in the oldest of the readjudication cases, where obtaining evidence from as long as 10 years ago may be impossible or nearly impossible. Also, how are we to decide such cases if in the end we are unable to obtain any evidence from the earlier period (or insufficient evidence to support an allowance)? Remember, in this situation we have also decided that we cannot presume disability from the date of application. (West Virginia On-Site Visit, 10/3-9/91; Atlanta On-Site Visit, 10/22-23/91)

Answer:

Normal development rules apply for requesting evidence in Zebley readjudication cases (see DI 32597.010C.3.). However, consider adjusting medical evidence of record (MER) request practices to expedite receipt of the current MER. In addition, in accordance with DI 32597.010B.13., every effort should be made by the DDSs in assisting the child, his or her parents, guardians, or other persons acting on the child's behalf in processing the claim. The Office of Disability (OD) has made contacts with the medical community to try to alleviate any problems that the DDS may have in securing medical evidence. OD has also worked on both the national and local levels with the Departments of Education and local school districts,

informing them of the value of their evidence and alerting them to the increased importance of this evidence under the new rules.

If attempts by the DDS to secure medical or nonmedical evidence/information are unsuccessful, and there is insufficient evidence in the file to make a favorable determination, the DDS should request the prior folder. The DDS will then render a decision applying the rules applicable to Zebley claims in DI 32597.010D. based on the available current evidence, medical and nonmedical, and the information in the prior folder.

Zebley Readjudication Cases-Application of the Medical Improvement Review Standard

13. Question: In a regular case, when we find that there is a "closed period," we are required to find that there was medical improvement related to the ability to work before we can also find that the claimant is no longer disabled. We assume that this rule also applies to "closed periods" in readjudication cases, but the POMS does not say so. Is our understanding correct? (West Virginia, On-Site Visit, 10/3-9/91)

Answer:

Yes. The medical improvement review standard must be applied in closed periods involving Zebley readjudication cases.

Zebley Pipeline Case-Unable to Locate File or Claimant

14. Question: On a Zebley pipeline case, the file has been lost and the claimant cannot be located. How should the DO/BO proceed? (We would recommend that, after thorough efforts to locate the claimant and/or the file have failed, the file should go to the DDS for an "insufficient evidence" decision.) (Atlanta, 5/3/91)

Answer:

We agree with Atlanta's recommendation, but with a slight modification. As Atlanta suggests, if thorough efforts to locate the claimant and/or file have failed, the case should go to the DDS for an "insufficient evidence" decision. However, we recommend that the case first be sent to the field office to reconstruct

as much as possible before being forwarded to the DDS. Under the circumstances outlined above, the proper decision basis code would be N-36 (Insufficient Evidence).

Transmitted 9/13/91 #3

Questions about these Q's and A's should be addressed to the RO Zebley coordinators. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf at FTS 625-9245.

Listing 110.06: Sex Chromosome Mosaicism

1. Clarification is needed on evaluation of Down Syndrome cases where the chromosomal testing reveals sex chromosome mosaicism. We would like confirmation that, per [the Office of Medical Evaluation] these cases should be evaluated under Listing 110.06 . . . . (New York, 4/16/91)

   Answer

   The regional office requested guidance about the proper listing under which to adjudicate a claim in which chromosomal analysis confirms sex chromosomal mosaicism. In the case example forwarded with the question, the regional medical consultant suggested that, despite the sex chromosome mosaicism, adjudication should be under Listing 110.06, which is intended for the evaluation of nonmosaic Down syndrome, instead of Listing 110.07.

   In the case example, chromosomal analysis showed a modal number of 47 chromosomes, with 19 out of 20 cells showing the additional 21 chromosome. One cell of the 20 examined differed in that it showed the trisomy 21 chromosome plus an additional x chromosome (48 xxx + 21). There were no normal cells. The laboratory report indicated that the analysis was consistent with the "primary form of Down syndrome (DS)." This would be consistent with a finding of trisomy 21.

   Despite the presence of the sex chromosome mosaicism, the overriding adjudicative guide in this case would be the presence of the trisomy 21 combined with the absence of any normal cells, which would not occur in cases of mosaic DS. Therefore, the region is correct in their assessment that Listing 110.06 is the appropriate listing under which to adjudicate this case and that this child meets that listing.

Functional Equivalence Examples

2. POMS DI 25215.015B contains a list (examples) of impairments that are functionally equal to the listings. Texas DDS has interpreted these examples to be automatic allowances. Should they presume that duration is met or do they have to

show/document that duration is met or will be met, e.g., #14, Tracheostomy in a child who has not attained age 3? (Dallas, 3/15/91)

Answer

All conditions that might qualify under the functional equivalence rule, including examples 1 through 15, are subject to the 12-month duration requirement. Duration is a requirement of the law. (See Questions #9 and 11 of Q and A #2 for a discussion of how to consider duration when using functional equivalence example 13.)

3. Example #14 - Does this mean that the tracheostomy must be in place currently? Or does this apply if the child has ever had a tracheostomy? (Dallas, 3/15/91)

One of the examples of functional equivalence (from Reg. 416.926a) is No. 14, "Tracheostomy in a child who has not attained age 3 - 103.03." If an older child, e.g. age 10, files a claim and has a history of having had a tracheostomy performed prior to age 3, is this a functional equals? Or is the critical factor that the child with a tracheostomy be under age 3 at the time of adjudication for a functional equals? (Kansas City, 3/18/91)

DI 25215.015B, Example 14 - Tracheostomy in a child who has not attained age 3. We can readily understand that chronic conditions requiring a tracheostomy would have a considerable impact on a young child's functioning and justify a finding of functional equivalence. However, the example seems to encompass all children under 3 with tracheostomies. Does this include emergency tracheostomies that are closed after the acute problem necessitating the trach has resolved? In many cases, the tracheostomy may remain open for only a few days. Should these cases be "automatically" considered functional equals allowances? (Chicago, 3/25/91)

Answer

A child with a tracheostomy must be under 3 years of age at the time of application, and the tracheostomy must have been in place for at least 12 months (or be expected to remain for at least 12 months) in order to apply this particular example. Given these parameters, it is possible to apply the example to a case of a child whose tracheostomy has been closed by the time of adjudication. Obviously, this can happen if your adjudication is more than 12 months after the application and the tracheostomy had been in place for a period of at least 12 months commencing from the time of

application. However, it can also happen less than 12 months after the application: Remember that, even though the SSI law does not permit payment of retroactive benefits before the date of the application, you may still consider months prior to the application for the purpose of establishing duration of disability. See POMS DI 25501.075B.

If you have established that:

- During the life of the application, a child's impairment was equivalent to a listed impairment based on the example of a tracheostomy, and
- The tracheostomy has been closed by the time of adjudication,

you will also have to decide whether the child is still disabled. As we have stressed repeatedly, there is no formula for this determination; it can only be done on a case-by-case basis. A child whose tracheostomy has been closed may still have an impairment or combination of impairments that equals listing-level severity on some other basis than the example; or may be disabled at the IFA step because of impaired development and functioning resulting from the impairment that required a tracheostomy; or may no longer be disabled. In the last case, your determination would be of a closed period of disability.

In the case of a child who is 10 years old, who had a tracheostomy before attaining age 3, and whose tracheostomy was closed years prior to adjudication, the example of functional equivalence based on a tracheostomy will have no relevance. (Given the same circumstances, in a readjudication case, the example of functional equivalence may be relevant.) Again, the child may or may not be disabled and may or may not have functional limitations related to the condition when he or she was not yet 3 years old. The only way to decide this case is based on the particular facts of the claim.

4. Example #15 - The charts that the DDS has show only 2 standard deviations instead of 3. How should they handle these cases? Will Central Office provide reference material that will show 3 standard deviations? (Dallas, 3/15/91)

Answer

Any point on a curve representing 3 standard deviations (SD) from the mean can be approximated by measuring one-half the distance from the mean to the 2 SD point, and using this distance to measure from the 2 SD point to the point that would represent 3 SD below the mean.

Equivalence to Listing 112.12: Appropriate Medical Consultant

5. If a child equals 112.12 (neurological functional equals under 1-year), would the determination have to be signed by a psychiatrist or psychologist? (Kansas City, 4/5/91)

Answer

No. In the situation in which a physical impairment is found to be functionally equivalent to Listing 112.12, the medical review should be performed by a qualified pediatrician or another physician who specializes in a field of medicine appropriate to the disability of the child. Pediatricians in particular are trained and qualified to evaluate the domains and behaviors in Listing 112.12.

IFA: Domains

6. Can a psychologist validly complete the IFA form sections that deal with physical domains (e.g., communicative development, motor development) or should these be addressed by a pediatrician or other somatic physician? (New York, 3/26/91)

Answer

"Communicative Development" is a component of the "Cognitive/Communicative" paragraph "B" criterion of the Childhood Mental Listings (112.00) and can be addressed by a program psychologist if it is a component of a mental impairment. It follows that communicative development or functioning in the IFA can also be addressed by a program psychologist under these circumstances. If necessary, communicative impairments that result from physical impairments should be evaluated by a pediatrician or other appropriate physician. (The same procedures apply at the IFA step as at the listings step: If you can make a fully favorable determination based on the existence of a mental impairment(s) without considering any concomitant physical impairments, it is not necessary to continue the evaluation. In all other cases, consideration of all of the child's impairments is required.)

Q&A #3 ; 9/13/91

"Motor Development" is also a "B" criterion in the age range 0 to 3 years and can be addressed by a program psychologist for children within this age range if it is judged to be a component of a mental impairment or if a distinction cannot be made because a child is too young to test. (Remember, too, that even though the childhood mental listings and the new childhood disability regulations direct special attention to the problems of testing infants under age 1--who are often difficult to test--they also remind adjudicators that age 1 is not a "magic" cutoff date; problems of testing children may continue beyond age 1, especially in the years up to about age 3.)

For children 3 years of age and older, when a causal relationship to a physical impairment has been ruled out, a psychologist may address motor development or functioning in the IFA only if the motor problem is clearly related to a mental impairment. A physical impairment should, of course, be addressed by a pediatrician or other appropriate somatic physician.

7. The IFA has a place to assess motor function, but should this be construed strictly in a musculoskeletal/neurological sense? For example, where would we notate the assessment of a child with a 60 decibel hearing loss? (New York, 4/18/91)

Answer

See the answer to the preceding question for the basic answer to the first part of your question. In essence, it states that the evaluation using the domains and behaviors in the new rules is focused more on the outcome of an impairment than on its cause. Hence, there can be many causes of impaired "motor" functioning as contemplated by the new rules, and they are not confined to musculoskeletal and neurological impairments. Your assessment on the IFA will reflect the outcome of these various impairments in terms of how they actually affect the child's functioning.

As a closely related aside, we want to remind everyone of something we taught in the Zebley training. The domains/behaviors in the regulations are, by our definition, all-inclusive of childhood functioning and development. The domains/behaviors in the new rules are commonly used by many professionals who treat and evaluate children. However, there are other ways of naming the domains/behaviors and of grouping functions. We have used these headings to group together the various childhood skills, abilities, functions, and behaviors for purposes of establishing uniform rules for assessing overall severity.

The most important points to remember are these:

- The first step is to assess all aspects of a given child's functioning--each specific activity, milestone, behavior, limitation, or whatever else is appropriate to an understanding of how a child is actually functioning or able to function.

- Only after this itemizing of specific functions/limitations has been accomplished do you categorize the functional impact in terms of domains and behaviors.

- In this respect, the childhood rules are akin in their approach to functional assessment at the end of the childhood sequence to the elements of an RFC assessment and the RFC assessment itself. The RFC considers certain elements, such as how much an adult can lift and carry, how long an adult can sit, stand, and walk, how well an adult can get along with coworkers and the public, the kind and amount of stress he or she can tolerate, etc. The assessment of these elements is made without regard to whether these abilities and limitations correspond to the exertional categories of unskilled work--"sedentary," "light," "medium," and so on.

The second part of your question asks about IFA assessment of a child with a sensory impairment that is severe but at less than listing level, specifically, a hearing impairment. The answer is that you would notate the assessment of such a child wherever you found limitations of age-appropriate development, functioning or behavior resulting from the impairment, just as you would with any other physical or mental impairment. In a case involving a serious hearing impairment, as you have described, you would expect to find some limitations in the communicative domain. As we explained at the training, a sensory impairment in an infant may also interfere with the infant's ability to bond with its parents, or result in cognitive or even motor delays. Older children may also have limitations in the social or personal/behavioral domains--for instance, at school, where there may also be evidence of learning delays--both in terms of development and age-appropriate functioning. (Incidentally, you do not mention the child's age in your example. We assume that the child must be over age 5, because a child under age 5 would meet the listings with an air conduction threshold of 60 dB in the better ear. We also assume that the child does not have a speech or language disorder which significantly affects the clarity

and content of his or her speech and which is attributable to the hearing impairment, as described in Listing 102.08B.3.)

The point is that there is no cookbook answer. You must assess each child's functioning on a case-by-case basis to determine how the child's impairment(s) actually affect him or her.

8. When an IFA is needed for a physical impairment, which IFA components would be most applicable? For example, a school-age child with asthma attacks may require some emergency room visits which occasionally require absence from school. How would the IFA address the impact of the condition? Would motor function be the appropriate domain? (New York, 3/22/91)

Answer

Physical impairments should be assessed under all of the domains/behaviors they affect. For example, if a physical impairment causes a child to be unable to perform age-appropriate self-care skills, the personal/behavioral domain should indicate some limitation. Likewise, if a physical impairment causes a child to be unable to engage in many age-appropriate social activities, this would be documented by indicating a limitation in the social development domain. In other words, a physical impairment could cause limitations in any of the domains or behaviors considered in the IFA, not just the motor domain. Therefore, there is no single answer to the question of which domain to choose when evaluating a given impairment; indeed, a single impairment may cause limitations in more than one domain.

The example you give involves a child whose impairment is "severe" and certainly might interfere with exertional activities. Therefore, if the facts of the case supported such a conclusion, you could find a limitation in the motor domain. This example also describes a "chronic illness," one of the "other factors" we must consider under DI 25220.015. As the POMS explains, it is important to consider the effects of a child's impairment(s) longitudinally, especially in the case of chronic, episodic impairments. Even though a child might function well between attacks, you must still consider the frequency of attacks, the kind of treatment required, the response to treatment (including whether there are any side effects), and all the other factors applicable to the case. When you know this kind of information, you will be able to make

informed decisions about how the impairment interferes with the child's personal/behavioral activities, socialization, motor abilities, and so on, judged over time.

The example in your question is not specific enough for a proper assessment: We would want to know how frequent the emergency room visits are, when they occur, why they occur (e.g., Is the child taking his/her medicine? Is the child's medicine sometimes ineffective? Is there something that triggers the attacks, that the child must therefore avoid?), how the child is treated in the emergency room and the response, and how the child functions between attacks, including whether the absences from school affect the child's grades or socialization with other students and the school staff, and whether there are any delays in development or learning of childhood skills because of frequent illness.

IFA Signature Requirements

9. During the regional training, it was indicated that the specialist for the primary impairment would be responsible for signing the case after discussing other impairments with the appropriate specialists. Is there a legal problem with a psychologist signing an IFA that is based on both psychological and physical problems? Many States do not have a psychiatrist on staff and will be relying on psychologists and pediatricians. (Philadelphia, 3/28/91)

How should the DDS handle situations where there are multiple impairments (one of which is mental) and the case is evaluated by a psychologist? For example, should two IFA's be prepared, one by the psychologist and one by the physical consultant, or should one IFA be completed (reflecting all impairments) and signed by both consultants? (Seattle, 3/19/91)

In multiple impairment situations where two or more consultants have made input, should each of the consultants complete an IFA (one reflecting mental limitations and one reflecting physical limitations) or should only one be completed reflecting all limitations? Should each consultant sign the IFA? On the SSA-831 can the psychologist (or pediatrician) sign the form and put a remark in item 34 that the case has also been reviewed by the other specialist? (Seattle, 4/29/91)

How should the IFA writeup and signature be handled when more than one medical consultant is involved in the evaluation (e.g., combined mental/physical case)?

Proposed Response (based on information received at Zebley training): If more than one consultant contributes to the IFA, each person's comments should be recorded in writing. These could be on separate IFA forms or on another form. Then, one consultant needs to prepare an overall IFA (this should be marked "overall" if separate IFA's have been prepared). The overall IFA cannot be signed by the psychologist in a combined mental/physical impairment case, even if the physical impairment by itself would be non-severe. Central Office prefers that the IFA not be signed by two consultants unless their individual comments can be distinguished on the form. (Atlanta, 4/1/91)

Answer

In answer to Philadelphia's question, a psychologist may assess functioning only from the perspective of a child's mental impairment(s). If a favorable determination can be made based on the mental impairment, without considering the physical impairment, a psychologist can do the IFA. As in adult RFC assessments, if a case requires an overall IFA that considers both mental and physical impairments, a physician must do the overall assessment.

In answer to the broader questions posed by Atlanta and Seattle, the ultimate conclusion regarding disability at the last step of the sequence must be based on findings about a child's overall functioning, which is a cumulative profile of the child's functioning in each of the applicable domains and behaviors. When a child has more than one impairment, no one of which in itself establishes disability, the effects of each impairment on the child's functioning may have to be considered singly (i.e., by more than one medical/psychological consultant) and must be considered in combination. (Of course, it is not always the case that the effects of each impairment must be considered separately by separate medical consultants; often, the medical consultant will be qualified and able to assess the combined effects of the impairments without having to refer the case to another medical specialty.)

When a child's impairments are assessed by more than one medical/psychological consultant, each consultant is responsible for preparing an evaluation in writing. The individual evaluations must then be integrated into an overall IFA. The overall IFA should be clearly identifiable and should reflect the assessments of each of the medical/psychological consultants who have worked on the case.

Ideally, each medical/psychological consultant who has assessed a child's functioning should prepare a separate document to avoid any confusion. However, this is not an absolute rule; there are situations in which it would be acceptable for multiple assessments to be recorded on one document. For instance, when a claimant has a combination of a mental and a physical impairment, it would not be unreasonable to have a medical consultant's and psychological consultant's assessment on the same document. Similarly, one document could be used in the (admittedly rare) circumstance in which both a psychiatrist and a psychologist have assessed functioning.

In cases in which more than one consultant's assessment is included as part of a single IFA, every precaution must be taken to ensure that the evaluation and comments of each consultant, and the overall IFA, are clearly identifiable. Each consultant contributing to the IFA should identify his or her comments under each domain and behavior assessed. If the IFA formats in DI 25220.100A-D are used, the consultant having overall responsibility for the assessment must sign and print his or her name in the boxes provided at the end. All other consultants must sign and print their names under the principal consultant's. If the IFA formats are not used, the consultant with overall responsibility should sign and print his or her name first, and the other consultants should sign and print their names below.

Choice of Age Category When Claim Covers More Than One Category

10. Concerning current claims, ZEBLEY class membership (child status - under age 18) is determined by the child's age at application date. Once the claim is taken and the development process begins, what is controlling in determining the proper age criteria utilized at the moment of adjudication, the application date or the exact age of the child when deciding the claim? Keep in mind the CDR process uses the date of decisions as the comparison points. It would seem that regardless of age at the application (e.g., 2 years, 10 months) one should use the age criteria, IFA format, etc. appropriate to the age after all evidence received (i.e., age 3 years plus).

Of course, a different procedure will have to be employed for the readjudication cases. (Kansas City, 3/6/91)

Answer

The principle is the same as the one we described in Question #13 of Q and A #2, regarding children who were under age 18 at the time of filing but over 18 by the time

of adjudication. Your evaluation should consider the child at each moment covered by the application beginning with the earliest applicable date. Hence, you must consider all appropriate domains and behaviors starting from the date of application and continuing until you find that the child is disabled (and assuming that there is no "closed period") or until the date of adjudication. In some cases (i.e., to establish duration), it may even be necessary to consider the child's functioning prior to the application date, and this might require consideration of domains and behaviors for an even younger age group.

Moreover, the boundaries of the age categories are not rigid. Thus, when a child is just over the borderline between age categories, it may be appropriate to use the domains and behaviors for the younger category. As we have stated in the regulations, POMS, and training, the age categories and domains/behaviors evaluated in each category are not to be applied in a mechanistic fashion. For instance, depending on the facts of a given case, it may be appropriate to evaluate responsiveness to stimuli in a child just over age 1 or to evaluate concentration, persistence and pace in a child just under age 3.

For cases that reach the IFA step of the sequential evaluation process, begin with an IFA at the earliest age covered by the application (generally, though not invariably, the child's age at the application date). You may or may not need to complete additional IFAs depending on the decision. However, if you are using only one or two of the domains and behaviors from an earlier age category to evaluate a child, as described above, you may use the IFA format appropriate to the child's age and modify it to show that you considered a domain or behavior from a different age category. If so, you may record this portion of the assessment in the section on other factors or in the case summary.

Nonmedical Evidence

11. We would appreciate guidance on whether evidence from non-medical sources (e.g., parents, teacher) can suffice for current documentation when there is no current medical evidence but the non-medical evidence indicates no change in the condition since the date of the last medical evidence.

Example 1: A child with meningomyelocele, last medical evidence is 1 and 1/2 years ago and showed at that time neurological abnormality; current information from the parent indicates that the child is wheelchair bound. [See #12 for Example 2] (New York, 3/26/91)

Answer

Under the law and regulations, we must have medical evidence from an acceptable medical source to establish the existence or severity of an impairment. However, evidence from sources who are not acceptable medical sources must also be considered when determining the severity of an impairment; i.e., how the impairment impacts on the individual's ability to function. The main restriction is that this evidence cannot form the sole basis for adjudication because it is not "medical evidence."

Once you have medical evidence establishing the existence of a medically determinable impairment that could be the cause of a person's limitations, the decision whether to update depends on the facts of the case, including what is wrong with the person, and the determination you are making. If the decision is to be a denial, the law requires you to obtain a complete medical history of the preceding 12 months. If the decision is to be an allowance, however, updating of the medical record is not always necessary. In some instances, the report of a single examination performed at any time will be sufficient for adjudication (e.g., where an injury or disease has resulted in permanent limitations). In other cases, multiple examinations may be needed.

There is not enough information in your example for us to render an opinion about the particular case. If the "neurological findings" were consistent with an impairment of such severity that you would expect the child to be wheelchair-bound, the evidence from the child's parents would probably be sufficient. (Indeed, depending on the severity of the neurological findings, evidence from the parents may not even have been needed to establish disability.) If the original neurologic assessment 1 1/2 years ago was explicit and detailed enough in outlining the spinal cord level and defining the residual neurological deficits, then the evaluating physician could reasonably predict the outcome and functional limitations expected in this case. If there were any uncertainty, a simple telephone call to the child's treating source to confirm the child's current status and need for a wheelchair could complete the evidence. Depending on the facts of the case, you might also obtain evidence from nonmedical sources, such as a followup with the parents or confirmation with daycare or school.

Nonmedical Evidence/Recency of IQ Testing

12. [Continued from #11] Example 2: A child with mental retardation and testing revealed IQ 65. IQ testing was done at age 5; child is now age 8. Current non-medical evidence indicates that the child is functioning at the same cognitive level. (New York, 3/26/91)

Answer

Section 112.00D, tenth paragraph, incorporates into the regulations our longstanding guidelines on currency of IQ testing. Under these criteria, IQ test results at 40 or above obtained before age 7 are generally considered current for one year. Therefore, an IQ of 65 obtained at age 5, as in the subject case, would not be considered current at age 8, and repeat testing would be necessary to establish current IQ.

The fact that the nonmedical evidence indicates no change, however, is also important. It must be considered for assessment of deficits in adaptive functioning which, together with the IQ scores, constitute the two parts of the capsule definition of Listing 112.05 (Mental Retardation). If the child's current IQ was too high to permit a finding of "meets," evidence about the child's adaptive functioning could be part of a determination finding equivalence to a mental listing. Of course, if the final record did not establish the existence of an impairment that met or equaled the severity of the listings--in which case an IFA determination would be required--consideration of the child's adaptive functioning would be crucial.

Drug Addiction and Alcoholism Sanctions

13. Will the sanctions for drug abuse/alcoholism (DA/A) apply to childhood cases, if the claim is allowed on the basis of DA/A? (Chicago, 3/25/91)

Answer

Yes. The law does not distinguish between adults and children in this regard.

Zebley Class

14. When we are adjudicating the Zebley readjudication cases, should we evaluate those individuals that are now over 18 as children and then also as adults? Do we prepare separate decisions? At what adjudicative level would decisions be made? (Atlanta, 3/18/91)

Answer

a. The answer to the first part of your question is "no." As in any case, you use the rules that are appropriate to the claimant's age during the time period you are considering. (See Question #13 of Q and A #2, and Question #10 above, for more detailed discussions of how you evaluate claims in which the individual was a child at the time of filing, but an adult at the time of adjudication.) Our special Zebley readjudication procedures require you to initiate development for the entire period. If current evidence shows that the claimant is disabled (under the adult rules, if the claimant is now an adult) apply the special procedures on presumption. If the presumption applies, you need go no further. (Since the new regulations for children are based on the principle of "comparable severity" to impairments that would disable adults, the presumption can be applied even though the decision was made under the adult rules.)

   If you must consider evidence from a time at which the claimant was under age 18, you would apply the new childhood rules for that period. When the presumption does not apply, any decision is possible: Continuous disability since the earliest application date; a finding of disability, but with a later onset; a "closed period"; multiple "closed periods"; or a "closed period" in the past and resumption of disability more recently.

b. There is no need to prepare separate determinations in cases that involve only one period; i.e., wholly favorable (even if it spans ages before and after age 18), wholly unfavorable, later onset, or a single "closed period." In cases involving multiple periods--i.e., multiple "closed periods" or a "closed period" in the past and a subsequent new disability that now continues--you should prepare separate determinations. However, remember that in any case it should be clear how you decided the case at each point in the life of the claim.

c. Readjudications under Zebley are initial determinations.

Regulations Basis Codes

15. What regulation basis codes should the DDSs input to the NDDS and SSR on DC cases where the child turns age 18 after filing but before adjudication? POMS DI 23505.015B states that the DDSs should leave the type of claim as DC and not change the type of claim to DI. This POMS then refers to the adult regulation basis codes in DI 26510.045B. However, the system will not accept adult regulation basis codes in DC cases per DI 26510.045B and SM 01005.440C.

Is C/O contemplating a systems change to accommodate these regulation basis codes for child cases or should we instruct the DDSs to prepare a desk aid for systems keyers on the comparable child regulation basis code for each adult regulation basis code for input purposes? (New York, 4/5/91)

Answer

DDSs should input childhood disability regulations basis codes for these cases. (You are correct in noting that the SSI system will not accept DI basis codes for DC cases.) Use the DC basis code that most closely approximates the appropriate DI basis code. For example, if the preferred DI regulation basis code is N31 (Capacity for SGA, Any Relevant Past Work) or N32 (Capacity for SGA - Other Than Relevant Past Work Engaging in SGA), substitute N40 (Individualized Functional Assessment Shows Impairment Not of Comparable Severity).

We are aware that systems changes are needed because of the new childhood disability rules. However, this type of change is far more complex than it would seem at first glance. Thus, it will be some time before a systems update can be effectuated. Until the system changes are in place, we agree with your suggestion that the DDSs may wish to develop desk aids for systems keyers.

16. What is the appropriate reg basis code for meets the listings involving statutory blindness? DI 26510.045 B. shows A61-981. Is this still to be used? (Dallas, 3/21/91)

Answer

The regulations basis code for these determinations remains A61.

New Claim Filed After Unfavorable Interim Standard Decision

17. We have had several telephone calls involving how to process pipeline cases in which a new application has been filed and is also being processed.

    1. If both decisions are being allowed we assume the new application would be considered a duplicate. We assume the DDS could complete only one SSA-831-U3 and one notice. Is this correct? Should the notice contain any special language that this decision pertains to both applications?

    2. If both decisions are being denied should the DDS prepare one or two SSA-831-U3's ? How many notices, one or two? Again, if only one notice is prepared should special language be included that explains that the decision applies to both applications?

    3. In both of the above situations what systems inputs should be made by the DDS? (Dallas, 5/6/91)

    Answer

    Only one decision is necessary. Both claims should be combined and one single determination prepared. No separate SSA-831-U3 is necessary. A remark can be shown to identify the second claim.

    The notice should reflect the criteria set forth in DI E32597.020 ff. The DDS/FO should add a single paragraph to the notice stating: "This determination also covers the application you filed on _____."

    The DDS should follow normal systems input instructions as shown in SM 06001.00 ff. DDS should be sure to enter SLC code of "Q" and should also correct the application date to reflect the date of the reopened application. Use the Update/Closure Mask (DUPD) to make corrections to the DDS system (see SM 06001.300ff.).

Whereabouts Unknown

18. FOs are reporting that some of these individuals [see Question 17] are not at the last known address and their whereabouts are unknown. We assume that the FO should follow existing policy and procedures on trying to locate these individuals and then send the case to the DDS for a decision. Is this correct? The DDS could request

additional evidence from existing sources, if it was appropriate. Would the DDS mail the notice to the last known address? (Dallas, 5/6/91)

Answer

The FOs should follow existing policy and procedures when trying to locate an individual (DI 11010.155 and SI 00501.515). If no up-to-date address is available, the FO will document the file regarding attempts to locate, prepare an SSA-831-U3 (DI E12597.005B.2.), and forward the file to the DDS for a new medical determination under the new childhood disability rules. After preparing a new determination, the DDS will mail the notice to the last known address. See IT 45-91, dated July 19, 1991, for more information on processing these cases.

Cooperation in Furnishing Evidence

19. FOs are reporting that in updating the files of the pipeline cases there are occasions when the claimants are not being cooperative in furnishing the additional information. We assume that after the FO documents their efforts at obtaining this information the file should be sent to the DDS for a decision since we told these individuals their cases would automatically be reviewed under the final regulations. Would the DDS be expected to recontact these individuals to try to get updated information the FO was not able to obtain? We realize the DDS could request additional evidence based on existing evidence in file but we do not believe the DDS should be required to recontact these individuals if the FO has already attempted to get this information. (Dallas, 5/6/91)

Answer

If the FO efforts to update the file (see DI E12597.005) have been unsuccessful, the FO should document its efforts, prepare an SSA-831-U3 (see DI E12597.005B.2.), and forward the file to the DDS for a new medical determination under the new childhood disability rules. We expect the DDS to use good judgment and to remember that one of the guiding principles of the new rules is that these claimants are children and cannot be held fully responsible for the execution of their claims. (See DI 25205.001A.1.c.) The DDS is not required to recontact the same individuals who failed to provide the FO with the needed information to update the file. However, if there are sources the FO did not contact and who could provide the needed information to update the file, the DDS should contact them. If there is a possibility that a DDS recontact could be successful, you

should assist the claimant and make the effort. See IT 45-91, dated July 19, 1991, for more information on processing these cases.

This is the second installment of the childhood questions and answers issued by the Childhood Disability Branch dated 5/15/91.

Questions about these Q's and A's should be addressed to the RO Zebley coordinators. Any questions that cannot be readily resolved in the RO may be called in to Sharon Arden at FTS 625-9098.

Additional Training

1. Will OD prepare a national training package which describes the normal developmental course of children, especially from birth to age 6? (New York, 3/7/91)

   Answer

   We have no plans at this time to prepare such a package. However, at the train-the-trainer sessions, we provided you with a paper that discusses early child development and urged you to provide copies of the paper to all DDSs, DQBs, and other staff who might make use of it. (It was the last item in the student manual, behind tab J-2.) We also explained that the new regulations and POMS have built into them many examples of normal development, functioning, and behavior in all of the age categories. The summary desk charts we provided to you at the training (tab G-5 in the student manual and tab IV-B in the instructor manual) are based on this information in the regulations and POMS.

Acceptable Medical Sources

2. Can school psychologists be considered acceptable medical sources since they appear to meet the criteria in 404.1513(a)(3) ("Licensed or certified psychologists")? In some states, school psychologists are certified by the State Board of Education; in other states (such as Florida) their certification comes from the State Board of Psychological Examiners which also certifies other categories of psychologists. Does the source of certification make any difference in whether the criteria for an acceptable medical source are met? (Atlanta, 3/8/91)

Answer

Before we answer the question, we want to briefly discuss the importance of knowing whether a person is an "acceptable medical source." The law requires an individual to be disabled as a result of a medically determinable impairment (or combination of impairments) "that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques." In practice, therefore, we require evidence from an "acceptable medical source" in order to establish the presence of a medically determinable impairment with "medically acceptable" evidence.

Beyond that, and especially when the issue reaches the point of determining the severity and functional impact of impairments, all relevant and material evidence must be considered. In childhood cases, this means that school evidence is especially important because schools are sources at which children are observed daily and which often test and evaluate many of the very kinds of functions we are interested in knowing about. For this reason, even though school evidence is frequently not "acceptable medical evidence" and, therefore, cannot be used to establish the existence of a medically determinable impairment, it is very important evidence for evaluating the severity of an established impairment.

As to the specific question whether school psychologists are acceptable medical sources, we refer you to the Federal Register publication of the final childhood mental listings that we included in tab A of the student manual. The first response in the left-hand column on page 51221 says:

> Current sections 404.1513 [the title II version of the regulation] and 416.913 [the title XVI version] provide that we will recognize as acceptable medical sources any licensed or certified psychologists; this includes school psychologists who are licensed or certified.

Therefore, school psychologists who are licensed or certified under our rules are acceptable medical sources.

Licensure or certification, however, varies from State to State, not only in the nature of the licensing/certifying body (e.g., State Board of Education, State Board of Psychological Examiners), but also in the level of professional responsibility assigned to a specific level of licensure or certification. For example, a "certified" psychologist may be able to administer an IQ test and provide the results, but may not be able to provide a diagnosis (as provided in Regulations 404.1513(b)(4) and 416.913(b)(4)), consistent with DSM-III-R and the Adult Mental Listings, reflecting not only IQ scores, but also adaptive functioning.

Our rule of thumb is that, to be an "acceptable medical source," the individual must be licensed or certified for the independent general practice of psychology. What this means differs in different States, although it usually means (except in 3 States and Puerto Rico) that the individual is a "Ph.D. psychologist" or "Ed.D. psychologist." (There are also exceptions for people who were "grandfathered" into licensure or certification by the States.) Ordinarily, we would not question a source with either of these titles. Other individuals may be licensed or certified, but it is ordinarily necessary to confirm their status as acceptable medical sources. However, this problem has wider implications than in "Zebley" alone or with regard to psychologists alone. We therefore plan to address it in a more general issuance.

Equivalence

3. Can a child with an impairment such as nephrotic syndrome who is steroid dependent be found to equal listing 101.02B? What criteria should be used to establish steroid dependence? (New York, 3/7/91)

Answer

Steroid dependence in nephrotic syndrome is equivalent to steroid dependence in juvenile rheumatoid arthritis under listing 101.02B. Steroid dependence in nephrotic syndrome is defined as a state in which recurrence of proteinuria, hypoproteinemia, lipidemia, and edema occurs when an attempt is made to withdraw the patient from steroid therapy that has successfully controlled the nephrotic syndrome. With resumption of steroid therapy, there is suppression of the proteinuria, hypoproteinemia, lipidemia, and edema.

Functional Equivalence Examples

4. When adjudicating a case based on one of the functional equivalents that establish disability to attainment of 1 year of age, should we correct for prematurity when setting diary dates? (Dallas, 3/19/91)

Answer

No. Correction for prematurity does not apply to setting diary dates.

5. Will OD issue a definitive list of life-sustaining monitors intended by DI 25215.015B, example 3? Would a sleep apnea monitor be included in this category? (New York, 3/7/91)

Answer

Taking the questions in reverse order, monitors in general, and sleep apnea monitors in particular, should not be considered to represent life-sustaining devices as intended by DI 25215.015B. The device must be required to sustain a vital function rather than only monitor that function. Examples of life-sustaining devices would include mechanical ventilators, central venous alimentation catheters, and indwelling catheters for continuous ambulatory peritoneal dialysis (CAPD). We do not plan to issue a definitive list of life-sustaining devices because it would not be possible to ensure that such a list would be complete. However, the foregoing list of examples is not an all-inclusive list of such devices; if you have any device in mind about which you are unsure, continue to write to us for guidance.

6. In DI 25215.015B, the fifth example of functional equals is "Marked inability to stand and walk; e.g. ambulation possible only with obligatory upper limb assistance." In the training material, this example is cross-referenced to listing 101.03B. However, that listing only refers to ambulation, not to standing in place. Case example 3 in the training material was a child who was found to be functionally equal to listing 101.03B. However, the child had no evidence of limitation in standing; he only had limitation on walking or other exertion. Can we assume that, in applying this example, limitation in sustained standing would not be required? (New York, 3/8/91)

Answer

Yes, the examples of functional equivalence in the regulations and POMS are only examples, not an all-inclusive list. In the training materials, the listings suggested for comparison were also only examples. Limitations of walking as intended by listing 101.03B would be consistent with a finding of functional equivalence.

7. The draft POMS DI 25215.015B Example 10 . . . defines a premature infant as "37 weeks or less" gestational age. This differs from the definition of premature infants in the instructor's manual where a premature infant is defined as a child born "at less than 37 weeks[*"*] of gestation. Which is correct? (Dallas, 3/20/91)

Answer

This is an inconsistency in both the POMS and the regulations. We will correct it when we republish the final regulations after the comment period.

Until then, follow the language exactly as written:

a. When deciding whether to compute a corrected chronological age, follow the definition in POMS DI 25216.001A.1, which is the same definition in the age regulation, Section 416.924b: A premature infant is one who was born at less than 37 weeks' gestation.

b. For purposes of using the special functional equivalence rules, use 37 weeks or less, although there should be no substantive difference in the determination. As we explained at the training, the definition of prematurity is, in a sense, immaterial to the outcome when you are using the two functional equivalence rules for low birthweight; older children (e.g., full term infants) who are born with the low birthweights and small size given in the functional equivalence examples are at least as seriously impaired as infants born at 37 weeks or less and should also be found to have listing-level impairments. Therefore, the only situation in which the inconsistency will make a difference will be in deciding whether to use a corrected chronological age for infants who were born at 37 weeks.

8. When considering Functional Equals Examples No. 10 and 11 (DI 25215.015), must we consider only the weight at birth, or can we consider any weight within the first few days of life (may be lower)? (Atlanta, 3/8/91)

Answer

We can consider any weight within the first few days of life (whichever weight may turn out to be lower).

9. What types of organ defects are expected to result in death during the first year without surgery as intended by DI 25215.015B, example 13? (New York, 3/7/91)

Would surgery for bowel obstruction fit the criteria of DI 25215.015B, example 13? This question was raised by physicians during the teleconference call we had to discuss the case examples/studies but was not resolved at that time. (New York, 3/7/91)

At the training, pediatricians asked about several specific conditions and whether these would qualify under Functional Equals Example No. 13 (Major Organ Dysfunction). These included patent ductus arteriosus, bowel obstruction, and pyloric stenosis. We would appreciate some guidance on these. (Atlanta, 3/8/91)

Answer

As you all know, we have been considering your concerns and thinking about the problem since the beginning of the training sessions, when the meaning of example 13 was first questioned. After some consideration, we offer the following guidance.

Any type of major congenital organ defect that could be expected, on the basis of informed clinical judgment, to result in death by 1 year of age can be included for consideration under Example 13. Infants should be found disabled under this rule when their impairments are so serious that a) based on clinical judgment, you would expect the impairment to result in death within the first year of life without surgical intervention, and b) there is a reasonable expectation, also based on clinical judgment about the kind of impairment and the kind of surgery required, that the child will continue to be disabled following surgery at least until age 1 year (this could be because of continuing medical severity following the surgery or because of recovery time following the surgery, or a combination of the two). The intent of this rule is to give the benefit

of the doubt to infants with very serious defects; therefore, the words "reasonable expectation" should not be construed to mean "probable" or "likely," only "reasonable," that is, based on sound judgment. If it is reasonable to expect continuing medical severity or functional impairment following the surgery, even if such severity or impairment is not a certainty, the child should be given the benefit of the doubt.

Given the foregoing, and even though bowel obstructions and many other conditions may be life-threatening, those that are easily correctable with relatively minor surgery or in which you would expect the surgery to be successful and result in the child not being disabled after recovery would not be included in this category. Of course, there are always exceptions to the rule, so it is important to remember always to consider the specific facts of the case before you and not to exclude automatically any condition (even bowel obstructions) from consideration under this rule.

10. Since physicians are reluctant to perform surgery during the first year of life, can we assume that where surgery has been done during the first year that the defect was life-threatening? (New York, 3/7/91)

Answer

The performance of surgery during the first year of life does not necessarily mean the defect was life-threatening at the time of surgery or that it would have been before the child reached age 1 year.

11. How should the DDS handle the claim of an infant (e.g., 1 or 2 months old) who has an organ defect, surgery is indicated by the treating physician but has not been done yet, and the child is asymptomatic at the time of adjudication? Should the DDS defer adjudication until surgery has been done? Would a duration denial be appropriate in light of the lack of symptoms? (New York, 3/7/91)

Answer

See the answer to #9. In the example given, it is not clear that the child has a major congenital organ defect that can be expected to result in death by age 1 year. If the child does not, then use of Example 13 would not be appropriate. If the child does have a major congenital organ defect that is expected to result in death before age 1 and that carries the reasonable expectation described in #9, above, he or

she should be found disabled, even in the rare circumstance that the child is asymptomatic. This is a special rule for finding equivalence: As we explained at the training, a finding of equivalence under this rule is automatic; therefore, it would not be necessary to defer adjudication until after the surgery, and it would not be appropriate to deny the claim for lack of duration.

12. Functional equivalence example No. 13.... Assume a claim is filed prior to age one but is adjudicated after age one. The child otherwise satisfies the criteria but at the time of adjudication, post surgical examination was essentially normal as in Case Example #1. Would a closed period be established assuming duration is established from birth to at least age one? (Kansas City, 3/18/91)

What would be the criteria for setting the ending date for a child given a closed period when disability is based on surgery for a life-threatening condition prior to age one year? (Atlanta, 3/19/91)

In certain functional equals cases, i.e., life-saving surgery cases where the claimant is currently asymptomatic should these cases be adjudicated as open-ended or closed period allowances, or should the decision be based upon the current medical findings? Example: A child born in February 1990 had a liver transplant done within the first year of life to correct a potentially fatal condition, biliary atresia. The claim is being adjudicated in March 1991. Chronologically, the child is 13 months old, and clinically is doing well. The child is essentially asymptomatic. What is the correct procedure for adjudicating such a claim? Is the intent of example 13 in the examples of functional equivalence to allow only for a certain set period of time or only during the pre- or post-operative convalescent period? Is the intent of example 13 in examples of functional equivalence to allow only until 1 year of age? If the transplant was performed at age 6 months, would this result in a durational denial? Should consideration be given as to whether the impairment is congenital, as are many impairments resulting in the need for surgical correction or major organ transplant? (Chicago, 3/25/91)

Answer

You may establish a closed period in these cases, except remember that a child who satisfies the criteria of functional equivalence example 13 is determined to be disabled from birth to the attainment of age 1. If the claim is filed prior to age 1 but adjudicated after age 1, a closed period can be established if the child no longer meets or equals a current listing, has demonstrated medical improvement related to the ability to work (as defined for children), and no longer has a disabling impairment. The ending date could be any month after the month of attainment of age 1, in which all the criteria (including the notice requirements) for a cessation are met.

This example is for major congenital organ dysfunction. It does not apply to children who require life-saving surgery due to other causes. "Congenital" has the same meaning as in the Dorland's Illustrated Medical Dictionary: referring to conditions that are present at birth, regardless of their causation.

Incidentally, since you mention organ transplants, the example of documented need for a major organ transplant (Example 1) is intended in part to address the experts' and advocates' concerns, as well as your questions over the years, that the listings may not reflect the current state of medical science. At the time they were written, the listings recognized only the possibility of kidney transplants because other transplants were either not done or were very uncommon. Since other transplants of major organs are now done with some frequency (e.g., heart, liver, and lungs) the example provides a method of including them at the equivalency step. All such major organ transplants have similar impacts on children's functioning, and therefore, provide a basis for a finding of functional equivalence.

Individualized Functional Assessments (IFAs)

13. If a claimant was under age 18 at the time of filing but is over age 18 at the time of adjudication, and has a severe impairment that does not meet/equal a listing, should the DDS:

    a. Prepare an IFA for the period before age 18?
    b. Prepare an RFC [assessment] for the period after age 18?

    (New York, 3/8/91)

    Answer

    The answers derive from guidance we provided in the Interim Standard Program Circular (No. 04-09-OD), Question 7. Essentially, you evaluate the case at each moment that is covered by the application and only stop if you find the claimant disabled (assuming, of course, that there is not also a "closed period").

    - Therefore, you first evaluate the claimant as a child. If the evidence results in an allowance under the childhood rules (and the claimant has been continuously disabled since onset) that is the end of the matter.

    - If while the claimant was still a "child" he or she was not disabled under the childhood rules, you continue to evaluate the claim to the present, considering the adult rules when the claimant attains age 18. If the claimant became disabled as an adult, you would establish a later onset date.

    In the second case, you would also be certain that the claimant's condition(s) was somehow worse at the time of this later onset than it had been at the time the claimant was a child. Remember: The new rules for children are intended to establish disability based on a standard of comparable severity to the adult standard. Therefore, it should not be possible for a

claimant who is, say, 17 years old to be found not disabled under the childhood rules, but to find the same claimant, with the exact same impairments and functional limitations, disabled under the adult rules at age 18; if you do make such a finding and there has been no change at all in the claimant's impairment(s), you will have to go back and rethink your decision for the period prior to age 18.

Based on the facts given in the question--i.e., the claim is being decided at the last step of the appropriate sequential evaluation process--the following guides on completing IFAs and RFC assessments apply:

a. Claimant disabled on the date of application, and has been continuously disabled: Prepare an IFA. No RFC assessment is needed.

b. Claimant disabled after the date of application but before attaining age 18: Prepare 2 IFAs--one for the period from the date of application to the date of onset of disability, and one for the period from the date of onset forward.

c. Claimant disabled on or after age 18: Prepare an IFA for the period prior to age 18 and the appropriate number of RFC assessments for the period after age 18 (see DI 24510.020C).

d. The claim is a denial: Prepare an IFA for the period prior to age 18 and the appropriate number of RFC assessments for the period after age 18.

Rationales and Functional Equivalence

14. In a case situation involving a functional equals, if medical advice is in file from the DDS consultant giving the functional limitations and the cited listing, does this information need to be restated in a rationale?

[Proposed answer:] Per POMS DI 25225.001B.1., a rationale is required for all allowances based on a finding that the impairment(s) functionally equals a listed impairment. Abbreviated rationale procedures do not apply. The rationale must contain the basic

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elements as outlined in POMS DI 26515.005. A discussion of the functional limitations and citation of the comparison listing on a medical advice form would not take the place of a required rationale. The first paragraph of POMS DI 26515.001 explains the multifold purpose of rationales. (Chicago, 3/25/91)

Answer

Chicago's answer is correct. We would add that a well-reasoned rationale explains to all subsequent reviewers exactly how the adjudicative team found functional equivalence, and makes it less likely that quality reviewers will find the decision in error.

Rationales and Individualized Functional Assessments (IFAs)

15. POMS DI 25255.001C.1.b. states that if an IFA was prepared, the findings produced by the sequential evaluation process will be summarized on the IFA and that these findings may be incorporated by reference on the 4268. It also says that the other elements required in the rationale will be included on the 4268.

    a. What elements of the rationale might not be included in the IFA? Could a list be provide of what items should be covered in the IFA case summary and what items should be covered in the rationale?

    b. If the IFA has everything needed for the rationale, will "See IFA Case Summary dated ..." suffice for the 4268? If so, is a 4268 still needed just to fulfill regulatory requirements or could this cross-reference be entered on the 831?

    (New York, 3/1/91)

    .... if sources are cited on the personalized denial notice (PDN) and rationale, must sources be cited on the IFA?

[Proposed answer:] An IFA should be completed before preparation of the PDN and rationale in cases where an IFA is required. A rationale is required in some instances where an IFA is not required, for example, allowances based on functional equivalence, technical denials, and not severe denials. In situations where both an IFA and a rationale are required, elements of the IFA can be incorporated into the rationale by reference. This is outlined in POMS DI 25225.001C.1.b., NOTE. Part D. of the appropriate IFA format can be incorporated by reference into the rationale. Since other parts of the IFA format require a summarization of evidence (Parts A.-C.), sources cited in parts of the IFA other than D. should not be incorporated by reference into a rationale or PDN, and would, in fact be redundant if Part D. is incorporated by reference. (Chicago, 3/25/91)

Answer

The IFA is designed primarily to document the functional impacts of an impairment(s) on a child. It might or might not include all the elements required in a decision rationale. For instance, the IFA must summarize the evidence used in reaching a decision, but if a large number of medical and nonmedical sources of information were considered, it might be inconvenient to list all of them directly in the IFA.

Likewise, the IFA might or might not include a complete discussion of any technical issues, such as whether work performed was an unsuccessful work attempt. If the issue is complex, the IFA might summarize it, with more detailed discussion on the SSA-4268.

If the IFA does cover all the rationale requirements in DI 26515.005, including citation of all the sources of evidence, an SSA-4268 is not required. It is important, however, that the IFA in such a case be clearly referenced on the SSA-831, so that quality reviewers at all levels can clearly identify the reasoning and evidence behind the decision. WE ARE AWARE THAT THIS ANSWER CONTRADICTS THE INSTRUCTIONS IN POMS DI 25225.001C AND WHAT WE MIGHT HAVE TOLD YOU AT THE TRAIN-THE-TRAINER SESSIONS. We have changed our position based on your input at the training sessions. We will revise the POMS accordingly.

Chicago is generally correct that part D. of the IFA will incorporate the findings in parts A.-C., and that, therefore, it would be redundant to reference parts A.-C. in the rationale. However, we did not mean to absolutely preclude referencing parts A.-C. if such referencing would make the rationale more clear.

The PDN explains the decision to the claimant, and should not refer to the IFA, a document the claimant does not have ready access to.

16. We need clarification regarding citation of sources of evidence. DI 26515.005A discusses elements common to all rationales. DI 26515.005B.4. specifies that nonmedical sources are to be cited. DI 26530.015B.1. specifies in personalized denial notices that all medical and nonmedical sources evaluated are to be listed. The IFA also requires citation of sources of evidence. It would obviously be redundant to cite these sources on three separate documents, i.e., the rationale, the IFA, and the PDN.

    Should both medical and nonmedical sources be cited?

    If nonmedical sources are to be cited should we include the information provided by parents, guardians, etc.?

    If we are to cite information required from schools should we list only the name of the school, or should we include the name of the teacher if known?

    We suggest DI 26530.015B.1. be followed for rationales and IFAs as well as for PDNs.

Finally, it would be preferable to cite all this evidence only once. Then we could cross-refer on the other documents. If you agree with this proposal please let us know which document should be used to cite these sources.

(Dallas, 3/21/91)

Answer

As you note, DI 26515.005 specifies that both medical and nonmedical sources must be cited in the rationale. This is particularly important in those cases that result in not-severe denials or functional equivalence allowances, and all IFA decisions.

Information provided by parents or other primary caregivers is very important in childhood cases and must be cited.

As stated in both DI 26515.005B.4. (for rationales) and 26530.015B.1. (for PDNs), nonmedical sources should be identified by position and organization, not by name. Other third parties should be identified generically; e.g., "Third party report dated xx/xx/xx," or, for PDNs "Other people who know of (child's name)'s health." We have made no change in this policy, and agree that it should be followed for rationales, IFAs, and PDNs.

As noted in the response to New York's question above, it is not necessary to cite the sources of evidence on an SSA-4268 if they are all cited on the IFA. Regarding the rationale vs. the PDN, we believe it has been DDS practice in the past to produce two SSA-4268s with the same citations, one for the rationale and one for the PDN.

17. Is an IFA required with the following regulations basis codes?

N36-916
N37-918
N38-916
N39-930

(Dallas, 3/21/91)

At Step 4 in the sequential evaluation process, we determine if the impairment(s) is of comparable severity to that which would make an adult disabled. ....The definitions given for the one allowance and various denial codes seem to indicate that the following regulation basis cades would require a completed IFA:

Allowance Code

A67-924	IFA establishes comparable severity to that of an adult.

Denial Codes

No visual/Visual Impairment

N40-924/N51-924	IFA establishes that impairment is not of comparable severity.
N34-909/N45-909	Impairment not disabling for a period of 12 months.*
N35-909/N46-909	Impairment disabling at time of adjudication but is not expected to last for a period of 12 months.*

*IFA or projected IFA needed if the level of severity is more than not severe but less than listing level for a period of less than 12 months.

The following denial reg. basis codes would not require an IFA:

N33-920(d)	Claimant engaging in SGA.
N36-916	Insufficient evidence furnished.
N37-918	Failure or refusal to submit to a consultative examination.
N38-916	Applicant does not want to continue development of claim.
N39-930	Applicant willfully fails for follow prescribed treatment.

We would like to have verification that our understanding is correct. (Chicago, 3/25/91, slightly paraphrased)

Answer

Chicago's list of denial bases that require an IFA is correct as far as it goes. However, you cannot state unequivocally that an IFA will not be needed for some of the second group of codes. Only N33-920(d), "Claimant engaging in SGA," and N38-916, "Applicant does not want to continue development of the claim," do not require IFAs in any instance. For the other codes, the need for an IFA will depend on the facts of the case.

When a claimant does not cooperate in furnishing evidence (N36-916) or fails to attend a CE (N37-918), the policy is that we will make a determination based on the evidence we have. See, generally, POMS DI 23010.001 and POMS DI 22510.055. (There is an exception for CDRs and failure to attend a CE. The regulations permit a determination that disability has ended because the person fails to attend a CE.) If there is sufficient evidence already in the file to determine that a claimant's impairment(s) is severe but does not meet or equal the listings, it will be necessary to do an IFA based on the available evidence and to determine whether the child is disabled. If the evidence is insufficient for an IFA, it would obviously be impossible to do one; in this circumstance, the file should be documented to show that an IFA could not be done and that the claim was denied because of failure.

Similarly, the policy is that failure to follow prescribed treatment (N39-930) does not become an issue until a determination has been made that a claimant's impairment(s) is disabling. See POMS DI 23010.005. Only then can a decision be made whether prescribed treatment would restore the ability to work--or, in the case of a child, the ability to function independently, appropriately, and effectively in an age-appropriate manner. Hence, you are required to take the case through every applicable step of the sequence (including the IFA step, if necessary) and determine that the child is disabled before considering the issue of failure to follow prescribed treatment.

However--and especially in cases of class members--be particularly cautious before denying a case on any of these bases. For instance, current SGA activity may not be relevant to the entire period covered by a class member's case. Also, we have agreed to be particularly careful in seeking cooperation from responsible adults who may be able to help, and the POMS requires special efforts to assist children in their claims, especially in cases in which the denial is based wholly or in part on a technicality such as failure to cooperate.

18. The Reg-Basis instructions of 3/7/91 for "DC claim and claimant under 18" will also need to be used for any DC claim where the claimant is over 18 since there is no comparable Reg-Basis code for A66-924 when the claimant is over 18. We will be processing Zebley readjudication cases on claimants that are currently over 18 and we generally process some DC claims where the claimant is over age 18 at the time of adjudication. If this interpretation is incorrect, we need a detailed explanation regarding the appropriate Reg-Basis codes to use in this situation. (Atlanta, 3/18/91)

Answer

Until further notice, use regulation basis code A66-924 for DC claims if the child is found eligible prior to age 18. Since functional equivalence does not apply to adults--i.e., persons who are age 18 or older--do not use the principle of functional equivalence or the new code if the date of eligibility is at age 18 or later.

Questions/Answers on Childhood Claims, No. 1

Here is the first installment of our answers to your questions. We will answer the remainder on a flow basis.

Our approach in this first issuance has been to copy your questions exactly as we received them and to indicate the region of origin and the date submitted. (We have grouped the questions under some general headings.) This way, you will be able to tell whether we have answered (or failed to answer) your question. If you have another idea, think this is unnecessary, or have any other comments or suggestions about the format/presentation of the Qs and As, we would be grateful to receive them.

Regulation Basis Codes

1. Will there be a separate regulation basis code for functional equals? (New York, 3/7/91)

   Answer

   On 3/13/91 we issued teletype IT-24-91 providing instructions for coding these cases. The regulation basis code for an allowance based on functional equivalence is "A-66-924."

Diaries

2. Are diaries for transplant cases on children (e.g., kidney, heart, etc.) the same for children as they are for adults? (Atlanta, 3/19/91)

   Answer

   We are in the process of revising the diary criteria. However, in the case of kidney transplants, see DI 26525.015A.5., which dictates that an MIE diary code of "E" be established. In other situations, if the impairment does not meet the mandatory MIE or optional diary criteria, use an MIP diary.

3. Draft DI 25225.005 discusses MIE diary being established in certain situations. However, there is no reason code provided. Please let us know which reason code should be used? (Dallas, 3/21/91)

Answer

For DI 25225.005B.a., the proper diary code in DI 26525.005 should be used. For situations cited in DI 25225.005B.b. and c., diary code "Y" or "Z" should be used as appropriate, per teletype IT-24-91, issued 3/13/91.

Applicability of New Rules Under Title II

4. The instructor's manual from the regional training stated that OD was considering whether or not to apply the new DC regulations to title II claimants under age 18 (DMCs and young wage earners). Has a final decision been made on this issue? (New York, 3/8/91)

Answer

No. We are still considering this issue. You will be notified when a final decision has been made.

Functional Equivalence Examples

5. When adjudicating a case based on one of the functional equivalents that establish disability to attainment of 1 year of age, should we correct for prematurity when setting diary dates? (Dallas, 3/19/91)

Answer

No. Correction for prematurity does not apply to setting diary dates.

Rationales and Individualized Functional Assessments (IFAs)

6. We need clarification regarding citation of sources of evidence. DI 26515.005A discusses elements common to all rationales. DI 26515.005B.4. specifies that nonmedical sources are to be cited. DI 26530.015B.1. specifies in personalized denial notices that all medical and nonmedical sources evaluated are to be listed. The IFA also requires citation of sources of evidence. It would obviously be redundant to cite these sources on three separate documents, i.e., the rationale, the IFA, and the PDN.

Should both medical and nonmedical sources be cited?

If nonmedical sources are to be cited should we include the information provided by parents, guardians, etc.?

If we are to cite information required from schools should we list only the name of the school, or should we include the name of the teacher if known?

We suggest DI 26530.015B.1. be followed for rationales and IFAs as well as for PDNs.

Finally, it would be preferable to cite all this evidence only once. Then we could cross-refer on the other documents. If you agree with this proposal please let us know which document should be used to cite these sources.

(Dallas, 3/21/91)

Answer

As you note, DI 26515.005 specifies that both medical and nonmedical sources must be cited in the rationale. This is particularly important in those children's cases decided on other than strictly medical grounds; e.g., not-severe denials, functional equivalence allowances, and all IFA decisions.

Information provided by parents or other primary caregivers is very important in childhood cases and must be cited.

As stated in both DI 26515.005B.4. (for rationales) and 26530.015B.1. (for PDNs), nonmedical sources should be identified by position and organization, not by name. Other third parties should be identified generically; e.g., "Third party report dated xx/xx/xx," or, for PDNs "Other people who know of (child's name)'s health." We have made no change in this policy, and agree that it should be followed for rationales, IFAs, and PDNs.

It is not necessary to cite the sources of evidence on an SSA-4268 <u>if</u> they are all cited on the IFA. Regarding the rationale vs. the PDN, we believe it has been DDS practice in the past to produce two SSA-4268s with the same citations, one for the rationale and one for the PDN.

7. It is not clear how the IFA case summary and the medical rationale interrelate and whether duplication of information will be necessary to properly complete these forms.

How detailed must the case summary be:

-- Are all pertinent medical sources to be listed?

-- What issues must be discussed in the summary?

-- Must each step of sequential adjudication be discussed?

-- Should "findings of fact" be included?

(New York, 3/1/91)

Answer

The pertinent medical sources may be listed on the IFA, or on the SSA-4268. (The IFA must summarize the essential facts of the case, but does not necessarily have to list every source.)

As discussed in DI 25220.025D and part D. of the sample IFA formats in DI 25220.100, the Case Summary is used to give an overall description of the child's functioning, to describe the functional consequences of the impairment(s), to discuss what the child can and cannot do, to discuss and resolve any conflicts in the evidence, to explain the conclusions that the child has a severe impairment but does not meet or equal the listings, and finally, to state whether or not the child has an impairment of comparable severity to one that would disable an adult.

Each step of sequential evaluation must be discussed sufficiently that a reviewer can clearly understand the reasoning and evidence leading to the conclusions at each step.

Findings of fact from parts B. and C. of the IFA format (e.g., a finding that a child has a marked limitation in a given domain) should be cited in part D. to the extent necessary to support the decision. The full descriptions from parts B. and C. of how the impairment and other factors affect the child's functioning should not usually have to be repeated in detail.

Zebley Readjudication Case, Claimant Over 18, Need For Payee

8. If a Zebley readjudication case involves a claimant that is now over age 18, is a payee needed? (Atlanta, 3/18/91)

Answer

Since the claimant is over age 18 he/she would now be treated as an adult with regard to any capability issue. Follow POMS DI 23001.010 for when to develop for capability.

FO Supplemental Questionnaire

9. The Field Offices have recently been sent draft POMS instructions that include an updated supplemental interviewing form for the Title XVI DCs. Are there any instructions being given any time soon that advises the FO to go ahead and begin using this latest format? If not, can we on the regional level advise them to? What about when we begin processing the interim standard denials under the new final procedures? Will the FO have to update the record, including this new interviewing format? (Kansas City, 3/6/91)

Answer

On February 13, 1991, we issued teletype IT-14-91 to the FOs, implementing the new regulations relating to the evaluation of disability for title XVI DC claimants. This teletype instructed the FOs to start using the Supplemental Questionnaire per POMS transmittals DI 11005.032 (Supplemental Questionnaire procedures) and DI 11095.166 (Supplemental Questionnaire exhibit), previously issued in draft. With regard to development of the interim standard denials, the answer depends on where the case currently resides. The FO will not have to update the record for cases pending a decision in the DDS--the DDS will obtain any necessary additional information per DI 25205.010C. However, the FO will update the file ~~required in adult claims decided on these bases~~. for these cases issued in the FO

8/13/91 Call Log "Broadcast (Cs & As)

SSA Program Circular

Disability

U.S. Department of Health and Human Services/Social Security Administration/Office of Policy

02-92-OD 01-92

Office of Disability,
Division of Disability Process and Policy

SATELLITE BROADCAST QUESTIONS AND ANSWERS ZEBLEY READJUDICATION PROCESS

Purpose

The purpose of this program circular (PC) is to address the questions about the readjudication process that were raised by the regional offices (ROs) and disability determination services (DDSs) prior to and during the satellite broadcast on August 13, 1991.

General Questions

Question 1: The P.O. Box number shown on the undeliverable checklist is different than the one shown in DI 12597.015.B. Which one is correct?

Answer: The correct P.O. Box is 17729 as shown on the undeliverable checklist.

Question 2: If a claim was denied for any reason other than "did not meet/equal" or "Was not expected to last 12 months" (i.e., failure to cooperate, whereabouts unknown, failure to go for a consultative examination) will it be excluded from the Class Member claims?

Answer: For purposes of readjudication, the Zebley class is comprised of any child who between January 1, 1980 and February 27, 1990 was denied or ceased for medical reasons. We are interpreting this to mean that any decision rendered by the DDS constitutes a medical decision.

Note: All interim standard cases will be automatically reviewed.

Distribution: All holders of POMS DI 001

SSA Pub. No. 64-044

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Question 3: Is the type of determination being made a "reopening" or simply a revised determination. A reopening requires specific entries on the SSA-831/832-U3 as well as certain language in the rationale. A revised determination would need only a new initial SSA-831/832-U3 and any rationale as required in this transmittal.

Answer: The type of determination is a readjudication of the entire period from the earliest Zebley application filed. These cases do not fall under the reopening rules, therefore, based on the specifics in the settlement agreement, the process as outlined in the readjudication POMS takes priority over current procedures in adjudicating these claims including the completion of the SSA-831/832-U3.

Question 4: Is the term "current representative" the same as class counsel? Or does "current representative" mean there is representation based on a signed SSA-1696-U4?

Answer: The term "current representative" refers to representation based on a signed SSA-1696-U4. All references to class counsel in the POMS specifically use the term "class counsel" (in this case Community Legal Services).

Question 5: What steps are necessary by the field office (FO) in cases where the claimant fails to cooperate?

Answer: SSA is to make every effort to provide assistance to the child, his or her parents, guardian, or other person acting on the child's behalf, to comply with all requests.

- In cases of non-cooperation special efforts should be made to locate an adult person responsible for the child's care including attempts to make a personal contact (personal contact means in writing or by telephone) with the child's family or custodian.

- SI 00501.515 outlines what action is necessary by the FO when the individual is not cooperating.

- In addition to the come-in and follow up letters, the FO must make at least two attempts at personal contact via phone on different days and times to try to secure the information needed to evaluate the claim. A busy signal does not constitute an attempt (IT 45-91).

- The file must be fully documented on a report of contact (SSA-5002) with the efforts made by the FO to secure the necessary information.

- For cases where there is no medical evidence in claims that are being denied at FO level, establish a SSA-450SI to post the decision. (While the process calls for the completion of a new application form, technically the application requirement has already been met.) Reestablish the claim as a start date record and include the appropriate denial reason on the input (N17).

- Send a copy of the denial notice to the Office of Deputy Commissioner for Programs, Litigation Staff (ODCP/LS) in central office (CO) in order to clear Civil Action Tracking System (CATS).

- If there is medical evidence in the file, the FO must forward the folder to the DDS for a medical determination.

- This is a new initial determination and the individual has full appeal rights.

Question 6: How should the FOs process a situation where a Zebley notice recipient wants to file a new application (either as a title XVI disabled child (DC) or possibly now as a title II and/or title XVI adult)? When, how and where will the Zebley claim be joined with the new claim?

Answer: The FO should take the new application and process as a current claim following existing procedures (see SI 00603.001ff).

If the blue responder jacket is received by the FO while the case is still pending in the DDS.

- Contact the DDS and advise them that additional information will be sent for the retroactive period.

- Contact the claimant and secure the needed information to update the file for the readjudication period.

- Do the necessary systems input to correct the date of application and any other information currently on the supplemental security record (SSR).

- Forward the folder containing the updated information for the readjudication period to the DDS for a medical determination. Only one decision is necessary for both claims covering the entire period.

If the DDS has already made a favorable determination and payment has been effectuated:

- Consolidate the claims (DI as well as DC claims) and

- Forward to Office of Disability and International Operations (ODIO) to process the retroactive period using the adoption procedure (see DI 12597.027).

If the DDS has already made a favorable determination and payment has not been effectuated:

- Effectuate payment on current claim, and

- Consolidate the claims (DI as well as DC claims), and

- Forward to ODIO to process the retroactive period using the adoption procedure (see DI 12597.027).

If the DDS has rendered an unfavorable determination:

- Secure the needed information to update the file for the readjudication period.

- Consolidate the claims and return the folder(s) to the DDS for a new determination. (Only one determination for the entire period would be necessary.)

Question 7: Will the undeliverables for the period 1980-1983 be screened out in ODIO?

Answer: No, ODIO will not automatically be screening out the subclass. It will be done by the CATS.

Question 8: Will the FO be able to find out how soon an individual response will be alerted?

Answer: We are not able to estimate how soon an individual's response will be alerted. We will be doing bi-weekly alert runs based on the number of alerts requested by the Office of Disability (OD). The FOs can find out the status of an individual's request for review by calling their regional Zebley coordinator. All ROs have access to CATS. CO will not be providing lists or tapes to FOs or DDSs. However, the ROs have the option to do so. Instructions and language on how to handle this type of inquiry can be found in IT-45-91.

Question 9: If the remailed notice is returned to CO as undeliverable will it be forwarded to the FO? What happens when a new address is not secured through the matching operations by CO?

Answer: If a new address is not secured through the matching operations on an undeliverable notice, we will not send the notice which was returned to the CO to the FO to remail. Currently, we are planning to send either a list of undeliverables to each FO or an undeliverable alert. LS, OD, ODIO and Systems are working on establishing the procedures on how to implement this and instructions will be issued as soon as the procedure is finalized.

DDS Issues

Question 10: Zebley cases must be tracked separately for fiscal purposes, but it is difficult to distinguish redeterminations on pipeline/interim standard cases from new cases. How can these cases be identified for fiscal accounting?

Answer: The supplemental funding received for the Zebley court case workload is to process the interim standard and retroactive case volumes. New childhood claims receipts will be processed from funds available for the regular caseload, not the Zebley funds, as these new claims are not being readjudicated under the court order.

You can identify the Zebley readjudication cases in one of two ways:

- o interim standard cases will contain a prior decision dated between February 28, 1990, and February 11, 1991.
- o retroactive cases will be received accompanied by "current information" material filed in a blue responder jacket. Retroactive cases will have a decision between January 1, 1980 and February 27, 1990.

To assist the Agency in determining the workpower expended on the Zebley workloads, special work sampling categories have also been established for tracking the resources associated with the Zebley case processing effort.

Question 11: To what extent is the DDS required to make referrals to the State Vocational Rehabilitation (VR) agencies? Will the DDS be able to make these referrals based on the requirements and capabilities on the particular State VR agency.

Answer: SSA's policy is that every case forwarded to the DDS for a decision of disability is considered for VR referral. This is particulary important with the Zebley readjudications since a significant number of these young people may be eligible for VR services.

Referrals of Zebley cases should be made using normal screening procedures. That is, DDSs should use the screening criteria outlined in DI 26520.025, except in those States where the DDS and VR agency have collaborated to refine referral criteria to meet the individual VR agency's needs.

Question 12: The DDSs are instructed to consider adjusting medical evidence of record (MER) request practices to expedite receipt of the current MER. That is, request current evidence and make a second request for the older MER on microfilm. Will we pay more for the MER requested in this manner? Will we pay twice, once for each separate request?

Answer: The Social Security Act, as amended, authorizes payment for the cost of making disability determinations, including payment for MER secured by the States to document disability claims. See DI 22505.040 and DI 39545.230 for DDS payment for MER.

MER is to be purchased in accordance with the DDS established rates of payment in their fee schedule. Payments are to be authorized in accordance with customary DDS procedures, and in concert with the guideline that the rate not exceed the highest rate paid by Federal or other agencies in the State.

We suggest that the States attempt to secure all medical information available from a source as part of a single request; allowing the source to split the request and provide the more current evidence sooner while the older less accessible information is supplied later. As such, the source would be offered a single payment covering the total request in line with the State's existing fee schedule.

If the source is unable to provide all the information requested, or if the source must resort to unusual special effort to obtain the evidence requested, then consideration can be given to adjusting the rate of payment for the evidence received within the parameters of the State's fee schedule.

Question 13: How does SSA intend to count these readjudication cases for workload and budget?

Answer: The State Agency Operation Report (FD-14) was expanded to handle a breakout for additional workload categories specific to the Zebley caseload.

Workload counts for these cases will follow the same procedures as for other cases.

On April 1, 1991, we released a memo to the ROs outlining the plans for processing interim standard cases.

On June 10, 1991, we released a memo describing the caseflow procedures to be used with the retroactive workload.

Separate funding for the Zebley workload was secured and subsequently released to the States to meet their expenses.

OD sent a memo (dated April 18, 1991) to all regional commissioners which outlined the funding and accounting procedures for processing this workload.

Question 14: Are the DDS batched folder requests to be sent to ODIO daily or weekly?

Answer: The DDS has the option of sending the folder requests daily or weekly. There is no set timeframe for sending these requests to ODIO.

Question 15: What FO telephone number should the DDS include in the notices to the claimant? The 1-800-number for the teleservice center or local office number?

Answer: The local office telephone number should be shown.

Question 16: Does the DDS have the authority to return folders to the FO that are not completed properly or have insufficient information?

Answer: Due to the high volume of cases involved in the Zebley readjudication, we would like to eliminate the movement of folders as much as possible. If the information that is missing from the files can be obtained by a telephone call or a DDS assistance request to the FO, this action should be taken rather than returning the folder.

FO Issues

Question 17: Will the monthly blue responder jacket releases be transmitted to the FOs simultaneously, or will they be sent on a flow basis?

Answer: Cases will be batched by district office code and released on a daily flow basis to the FOs.

Question 18: Will the late filers be sent to the FOs for late filing development as soon as the cards are received in ODIO?

Answer: No, all reply forms are processed in order of receipt and in the same manner.

- The blue responder jacket will be sent to the servicing FO and the alert will contain the legend "Late Filing Good Cause Development Necessary."

- The FO will complete the good cause development first, and then begin to process the readjudication case if good cause for late filing can be established.

Question 19: SGA--Since regular cessation and EPE rules apply before July 1987 to title XVI claims, instructions should be given on processing cessations, terminations, reentitlement, etc. If the cessation provisions will not apply to Zebley cases, the procedures should specify.

Answer: In addition to the streamlined income and resource provisions, streamlined SGA provisions are also being used. Rules that were in effect beginning July 1987, are also being applied for months prior to July 1987 (see DI 13010.001).

Question 20: Is there any special provision for release of large accruals?

Answer: There is no special provision for release of underpayments in, say, installments. (While underpayments, being made by OTP, are issued in amounts of no more than $9,999.99, these are not considered "installments.") Neither, is there any exception to the requirement that countable resources resulting from the underpayments be counted after 6 months.

However, the award notices sent to class members provide detailed information on what is and is not countable, and, further, give information on establishment of excludable trust arrangements.

Question 21: How does the FO know whether there is a Medicaid issue if the child is deceased?

Answer: DI 12597.030.C.11 refers to SI 01730.015 which states that in section 1634 States when there are unpaid medical expenses the DDS will do a medical determination <u>if the State Medicaid agency requests one.</u> Therefore, the FO will be informed of an issue either by the inquirer, the Medicaid agency, or the DDS. If the inquirer has not already been in contact with the Medicaid agency on the issue, they should be referred there. If a State has elected not to pay retroactive medical bills for the pre-February 20, 1990 period, the Medicaid agency presumably will not request the medical determination for unpaid bills in that period. As of this writing, no 1634 State has indicated it will pay retroactive bills for the pre-February 20, 1990 period.

Question 22: How will the FO obtain the blue responder jacket on a hardship or terminal illness case? How will priorities be established?

Answer: Teletype number IT-45-91 addresses the issue of processing hardship cases. A method has been developed to generate alerts on these cases. Alerts will be generated weekly for hardship cases. Requests for alerts in hardship or dire need cases will be coordinated at the regional level. The FO should send an administrative message to the regional <u>Zebley</u> coordinator.

Question 23: If the FO only gets a blue responder jacket how will the FO know if there was an authorized representative?

Answer: At the interview the FO should determine if there is or has been an authorized representative.

If the claimant has had a representative, the FO will include this information in the folder being sent to the DDS.

Question 24: Will a telephone call suffice as a request for a review of the retroactive claim?

Answer: An individual may contact the FO in person, in writing, or by phone. If the individual contacts the FO by phone, the FO must prepare a SSA-795 requesting review and send to the individual for signature. After the signed SSA-795 is received it is forwarded to ODIO for processing.

Question 25: In initial claims, the unsuccessful work attempt is a DDS decision. If during the FO interview it is determined that the individual had an unsuccessful work attempt, what action is necessary by the FO?

Answer: The FO will secure the necessary development, i.e., SSA-821-F4 regarding the individual's work activity. The DDS will make the final decision as to whether or not the work attempt was successful or not.

Question 26: Is it necessary for the individual to come to the FO to provide information to process the retroactive claim or may the FO take a teleclaim?

Answer: It is not a requirement that the individual come in to the FO for the interview. Required information can be obtained by the telephone.

Question 27: If the claimant requests review under Zebley and, upon contact, states that they do not wish to pursue the claim, how do we close the case out?

Answer: Secure a SSA-795 indicating the individual does not want to request review of the prior claim under Zebley, and understands he/she is giving up the right to have the child's claim reviewed. Send SSA-795 to the LS in CO.

Claimants over age 18 must be contacted directly to see if they wish to pursue. If the person with current custody of the child is NOT the person who had custody at the time of the Zebley application, the person with current custody should be contacted to see if they wish to pursue.

Destroy the Zebley blue responder jacket and contents after mailing SSA-795 to ODCP/LS.

Question 28: When does the FO need to screen the case for class membership and when does ODIO?

Answer: The FO does not have to screen a case until they receive a blue responder jacket. Even if ODIO has screened the case the FO needs to reverify class membership by review of queries located in the blue responder jacket from ODIO. ODIO will also screen walk-in inquiries.

Systems Issues

Question 29: Will the FO have sufficient supplies to work readjudication cases or are we going to have to reproduce everything locally? When can FO expect to receive the supplemental questionnaire form?

Answer: The FO will be required to put the notice language on their local software (FONS). The undeliverable checklist and screening sheet must be reproduced locally. The supplemental questionnaire has been sent to the Office of Management and Budget (OMB) for approval. OMB needs approximately 60 to 90 days to complete their review. If OMB requires no substantive changes to the questionnaire, we expect the form will be in the FOs by December.

Question 30: In a non-deferred case (e.g., someone who has AIDS; or is 1/2 of a couple) does the FO keep the record in hold code (H80) until the decision comes in? What about updates?

Answer: SM E01901.002.B. contains instructions for establishing records in various case situations. FOs should follow these instructions along with the instruction in SM 01010.055 concerning use of payment status "H80" for cases awaiting disability decisions. Existing procedures apply when processing updates to a claim while the disability decision is pending.

Of course, if presumptive disability (PD) applies, the case should be set up as a start date case with PD and Zebley data included on the same transaction. Payments can be made if the PD criteria apply.

Question 31: Some child cases that now meet the definition of a Zebley court case were established on the SSR before specific Zebley court case instructions were received. It is now necessary to make systems input that will identify these cases as Zebley court cases for control and tracking purposes and to exclude them from FO processing time statistics. Please describe the systems input that will be required.

Answer: The T50/start date actions would be appropriate. The start date transaction should include the Zebley data.

Question 32: When a prior folder is requested, we can medically defer the case. How long can we defer? What reason code and ending date is input to the NDDSS?

Answer: The medical deferment code that can be used is:

I0-- other deferment codes (not applicable to this situation) are:

(H0=Litigation
J0=Special Studies
K0=Policy Changes
L0=Legislation)

An ending date is only required at time of clearance and not at time of input of medical deferment code.

DDS Evaluation Issues

Question 33: On reconsiderations, must the DDS complete another individualized functional assessment (IFA) if they are affirming the denial as written?

Answer: Yes. Since a claimant is entitled to a new determination at each decisionmaking level, a new IFA must be made, regardless of prior IFAs.

Question 34: We expect that a significant number of the readjudication cases will involve claimants who are currently over age 18, and we feel that the DDSs need additional guidance on how to handle these cases if the claimant is not currently disabled using adult criteria, but would be an IFA allowance using pre-age 16 criteria at an earlier age. Are multiple IFAs needed in this situation? Can the DDS apply the presumptions? Must they attempt to secure the prior folder? Can a closed period be established in the absence of medical improvement as defined in DI 28010.015, on the basis that the claimant's impairment has decreased impact on the ability to function because of the maturation process? The same questions are appropriate if the claimant is currently not disabled under age 16-18 criteria, but would be an IFA allowance prior to age 16.

Answer: This question presents a number of different issues which we will address in the order in which they are raised.

The first part of the question points out that there can be situations in which an adult might not be found disabled while a child under age 16 with the same limitations would be found disabled. As we indicated in question 13 of the second set of questions and answers on Zebley, issued on May 15, 1991, the new rules for children are intended to establish disability based on a standard of severity that is comparable to the adult standard. Although we agree it is possible that a child under age 16 might be found disabled while an adult at age 18 with the same limitations would not be found disabled, this is because the limitations could have a greater impact on the child's ability to engage in work-related activities.

Generally, although not invariably, the age principle is inverted in childhood cases as compared with adult claims. In adult claims, we consider advancing age to have an increasingly adverse impact on the adult's ability to adjust to other work or to begin work for the first time. Therefore, it often happens that an adult who is of advanced age (age 55 or older) might be found disabled while a 20-year-old with the same limitations would not be found disabled.

In children, the opposite principle of age generally applies; that is, in general the younger the child, the greater the impact of the impairment on the child's ability to engage in age-appropriate activities may be. As in adult claims, this is not an invariable rule but general guidance. You always have to evaluate the effects of the impairment(s) on the particular child. Indeed, sometimes impairments acquired by older adolescents can have a devastating impact on functioning, such as when the child loses skills and must relearn them or learn to adapt.

The use of age as a factor in evaluating title XVI child claims is explained in more detail in DI 25210.001.

The next part of the question asks how many IFAs would be necessary in the situation where the claimant, who is now an adult, is not currently disabled, but the limitations would be considered disabling in a child under age 16.

We cannot assume that current limitations had the same impact at an earlier point in time. If the individual is not currently disabled, then we still have to evaluate the claims from the point of the earliest Zebley application forward. If an IFA is required, it should not be based on the current limitations, but should be based on evidence of how the child was actually functioning, or able to function, at that time.

You have also asked if the presumptions can be applied and whether the prior folders must be secured in those situations where the claimant is an adult and current disability cannot be established, but the limitations would result in a finding of disability for a child under age 16. Since current disability cannot be established, you cannot presume that a continuous period of disability existed as of the earliest readjudication application date. Whether or not prior folders will be needed will depend on what the evidence shows. If a claim was filed which covers a period for which we cannot establish disability, the prior file will be needed. If the prior file cannot be located retroactive medical evidence of record should be developed.

The last part of the question deals with closed periods of disability and asks if they can be established when no medical improvement has occurred but, due solely to the maturation process, the claimant is now functioning better.

Unless an exception applies, disability cannot be ceased without medical improvement being demonstrated. As explained in the childhood regulations that were published on February 11, 1991, medical improvement is any decrease in the medical severity of the child's impairment(s) which was present at the time of the most recent favorable decision. 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 the child's impairment. For children, symptoms, signs and laboratory findings may include any abnormalities of physical and mental functioning that were used in making the most recent favorable decision. Of course, medical improvement must be related to the ability to work, as defined for children, and the claimant must no longer be disabled. 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.

Question 35: Paragraphs 1414, 1415, and 1424 are listed for use in the notice the DDS sends. What about paragraph 1425? The DDS can use MINE diaries on DC claims that meet adult listings on the MINE list.

Answer: Paragraph 1425 is used to explain SSA's case review requirements in cases where medical improvement is not expected. It can be used for DC claims in which the DC meets an adult listing on the MINE list.

You may have already received a transmittal outlining the new criteria. This transmittal permits MINE diaries in any childhood claim where revised MINE criteria are met.

Question 36: Can "med-voc" allowances (either C1-1520(f) or A63-920(f)) be adopted when the DC can be presumed to have been a "comparable severity" (A67-924) allowance? What reg-basis code should be used in this situation? Does the DDS need to prepare full rationales for adoption of med/voc allowances or use the adoption statement and the short rationale documenting the reasonable presumption?

Answer: We can apply the presumption for any claimant who is found to be currently disabled on any basis, provided there is no contrary evidence in file (such as traumatic onset of disability or a new impairment) or medical judgment to determine that the impairment was not disabling from the earliest readjudicated application. If a claimant is now an adult who is determined to be currently disabled based on the medical/vocational criteria, and the presumption applies, use reg-basis code A67-924. A simplified rationale would be needed to document the presumption.

Question 37: DI 25225.000 requires complete decisional rationales for IFA allowances and functional equals allowances. If disability is presumed and the current decision is an IFA or functional equals allowance, do we address presumption in the complete rationale?

Answer: The rationale requirements in DI 25225.001 are separate from the rationale requirement in DI 32597.010D.2.b. If current disability is being established based on functional equivalence or having an impairment of comparable severity, a complete decisional rationale is required. If the presumption is also being applied, the presumption rationale can be incorporated into the decisional rationale.

If current disability is established based on meeting or medically equalling a listing, or based on medical/vocational considerations (i.e., the claimant is currently age 18 or older), and the presumption applies, the simplified rationale will be the only one required.

Question 38: How do the IFA's and new mental listings tie in with age (i.e., is it age now or age at date of earliest application which could be 11 years ago)?

Is an IFA to be completed in determining current disability if the DC is now an adult? Can or should the adult criteria be used?

Answer: In response to the first part of the question, the age to be used is the one applicable to the period of time being evaluated. When current disability is being determined, the current age is used. If the DDS is determining whether the child was disabled at the time of the earliest Zebley application, the age at that time will be used. If disability cannot be established at the earliest point and the applicable domains and behaviors change between that point and the date of adjudication then another IFA should be prepared. See question 2 in questions and answers number 4, dated October 8, 1991.

In response to the second part of the question, if the claimant is now an adult, an IFA should not be used to determine current disability. The adult criteria must be used for this determination.

Question 39: Please provide an example or a brief explanation for the rationale which explains why the presumption could be applied.

Answer: Since each case is different, we have not developed stock language to use in the rationale for applying the presumption. However, the rationale should cite the impairment, why it is reasonable to assume that the condition was disabling at the time of the earliest Zebley application (e.g., the condition is a static one and, therefore, it is reasonable to assume a consistent level of impact on the child's functioning), and a statement that there is no contrary evidence.

In situations where the presumption rationale is not being incorporated into a decisional rationale, i.e., current disability is based on meeting or medically equalling the listings or on the medical/vocational criteria, the presumption rationale should also include a brief statement about why the impairment is currently disabling.

Question 40: If the DDS receives sufficient evidence to support a current and fully favorable retroactive allowance (see DI 32597.010.B.6 and DI 32597.010.B.7), is it necessary to wait (or follow-up) for prior MER that has been requested? Can the DDS adjudicate in accordance with DI 32597.010.D.2.?

Answer: If the DDS receives sufficient evidence to support a current allowance and the presumptions apply, there is no need to wait (or follow-up) for prior MER that has been requested.

Question 41: If we are able to prepare a current favorable decision, and the claimant advises that this impairment was present at the earliest application, would this be sufficient to presume onset?

Answer: No, but the claimant's statement should be considered. The DDS must also consider the medical evidence and other evidence in file as well as use medical judgment to determine if the current disabling impairment(s) was disabling as of the earliest reopened application date.

Question 42: DI 32597.010.B.6. and D.2.a. - Please provide an example for presuming that the current disabling impairment was disabling as of the earliest reopened application. If a child is currently disabled as an adult at age 23 and was denied in 1981 at age 13 must all available MER be requested between 1981-1991 before disability can be presumed? Will it be possible to presume disability in some cases without requesting all MER back to the earliest application?

Answer: This question also raises several issues that we will address in the order raised.

You have asked for an example of a situation where the presumption could be applied. There will be many cases in which this will happen; however, since every child is different, it is impossible to issue a list of impairments for which the presumption should always be applied. One example though, might be the following type of case:

- The child is mentally retarded (a full scale IQ of 68 with deficits in adaptive functioning);
- The child has no other impairment;
- The earliest Zebley application was filed when the child was age 6;
- The child is still under age 16 at the time of the readjudication; and
- The current evidence shows a moderate limitation in social functioning and personal/behavioral functioning.

Considering that mental retardation is a relatively static condition, it would be reasonable to presume that the functional deficits currently being exhibited were present at the time of the earliest Zebley application.

You have to use professional judgment in deciding whether or not the presumption can be applied. If the current disability had a traumatic onset after the prior denial, obviously you can't presume disability all the way back. If the condition is one that is progressive over a long period of time, it might not have been as serious at the time of the earliest Zebley application.

You have also asked if all available MER must be requested before disability can be presumed. In adoption cases (see DI 32597.012) if the claimant is currently receiving disability benefits under either title II or title XVI when the readjudication process begins, the ODIO examiner will attempt to apply the presumption without requesting any additional MER. If the presumption cannot be applied, or if the claimant is not currently receiving disability benefits, all MER, from the earliest Zebley application on, will need to be requested.

Remember, you may have to request functional as well as medical information for the retroactive period.

Question 43: When a claimant is represented, will all folders received in the DDS have a completed SSA-1696-U4 in file?

Answer: If a claimant is represented, a remark will be on the SSA-831-U3 or a copy of the SSA-1696-U4 will be in file.

Question 44: In the Zebley readjudication cessation cases where no prior folder(s) exist and no retroactive MER is available, the DDS must prepare a determination to continue benefits. Is this continuance considered the comparison point decision for future CDRs?

Answer: Yes. The DDS must develop all medical evidence for the entire reopened period. If the prior folder(s) or redeveloped evidence from the time of the CPD cannot be obtained, a finding of medical improvement cannot be made, and a continuance (SSA-832-U3) determination is required.

Question 45: Are readjudication cases going to be reviewed by Tier II using current procedures and thus have no deficiencies charged to the DDS?

Answer: Readjudication and interim standard cases will be reviewed by the Disability Quality Branches and, if appropriate, deficiencies will be cited and returned for correction. However, these deficiencies will not be counted in the compilation of DDS's quality assurance accuracy rates for standard of performance purposes. Error rates and trends will be monitored and appropriate corrective actions will be taken.

Question 46: The DDS procedures for deciding the readjudication process in retroactive cessation cases are not clear where the DDS has obtained the prior folder(s) and/or retroactive MER has been obtained.

Answer: If the individual is currently disabled, but the DDS cannot apply the presumptions back to the cessation date, the DDS will:

- Evaluate the evidence to determine if the original cessation or any subsequent cessation was proper under the new childhood disability regulation; and

- Prepare an SSA-832-U3 continuance effective with the month of cessation if the impairment was continuously disabling.

However, if the disability cannot be reestablished back to the month of cessation, the DDS will prepare an SSA-832-U3 affirming the prior cessation and an SSA-831-U3 to reestablish disability effective with the first date from which it can be reasonably concluded that the impairment was continuously disabling.

If the individual is not currently disabled, the DDS will:

- Evaluate the evidence to determine if the original cessation or any subsequent cessation was proper under the new childhood disability regulation, and

- Prepare an SSA-832-U3 affirming the prior cessation if the disability was not continuously disabling.

If disability was established back to the month of cessation but later ceases, prepare an SSA-832-U3 determination showing a later cessation date.

Either way if you cannot make a fully favorable decision, you must request the prior files if there is evidence that prior files exist.

Question 47: How does the DDS know if the SSI claimant is already receiving another title II benefit, other than disability?

Answer: The FO will include the appropriate remark on the SSA-831-U3. FO instructions were issued via memo dated May 7, 1991. POMS instructions will follow.

Question 48: Per DI 27505.020.B. SSA does not generally pay benefits because of a change in legal position earlier than the date of the change of position. In Zebley readjudication cases does this policy apply to the decision of presuming that the child has been disabled since the earliest date of application? For example, if a child now meets one of the new childhood mental listings, would we be precluded from presuming disability with no additional evidence prior to December 12, 1990?

Answer: If a child now meets one of the revised childhood mental listings, disability could be presumed (If all other factors necessary to apply the presumption are met) prior to December 12, 1990 (date of adoption of new mental listings). Procedures required by court decisions can override procedures normally required by the regulations on administrative finality. Under Zebley, SSA will readjudicate the claims of all title XVI childhood disability claimants who received a less than fully favorable decision of the Secretary, or whose SSI childhood disability benefits were terminated, on or after January 1, 1980 thru February 27, 1990 based on medical grounds and requested readjudication of their claim. In addition, claims denied under the interim standard will be automatically reviewed under the new regulation.

Question 49: If the DDS has initiated additional development and it is later determined that the evidence will not be available within 60 days, or if it is necessary to request the prior folder if the presumption cannot be applied, can they return the case to the FO for release of current benefits with later return to the DDS for completion of onset development?

Answer: No. Current benefits can only be paid in those situations where it is known in advance that the development cannot be obtained within 60 days (e.g., school is closed for the summer). Due to the high volumn of readjudication cases, we want to limit folder movement as much as possible and reduce the burden on the FO in effectuating payments.

Question 50: Exhibit 5 "Zebley Folder Request Memo." Is the DDS to reproduce this form locally?

Answer: A one time printing and distribution was made to all DDSs in mid-July. If any additional copies are needed, the DDS should reproduce locally.

Question 51: Are medical sources needed on the SSA-4268-U4/C4 when we are explaining why the presumption principle can be applied?

Answer: Medical sources need not be listed on the SSA-4268-U4/C4 when explaining why the presumption principle applies.

Question 52: Some States do not prepare merged text notices. Is it acceptable to use the standard reference paragraph (409) to the personalized denial notice (PDN) in the notice instead of the PDN itself?

Answer: Yes. Paragraph 409 is the appropriate paragraph to use when the DDS does not prepare merged text notices.

Question 53: Can the DDS process a denial or cessation without the prior folder if they have enough old MER to fully document the file?

Answer: No. The prior folder must be requested whenever a fully favorable determination cannot be made.

Questions asked during Broadcast

Question 54: Are folders going to be released after August 30, 1991?

Answer: No, as alerts are received they are associated with the queries and placed in the Zebley blue responder jackets which are then dispatched to the FO. The first blue responder jackets were released the second week of August. From that time on, responder jackets will be released on a flow basis.

Question 55: Will adoption cases be returned to FO for payment?

Answer: Yes, if ODIO is able to make a favorable determination, the case will be routed to the FO to effectuate payment as per DI 12597.035 ff.

Question 56: Will adoption procedures include title II only, title XVI only and concurrent title II/title XVI cases?

Answer: Yes. If an individual is currently receiving title II only, title XVI only or concurrent title II/title XVI payments the adoption procedures could be applied. ODIO is now responsible for processing all adoption decisions (title XVI only, title II only, or concurrent title II/title XVI).

Question 57: What happens if a child has died?

Answer: If a blind or disabled child was living with a parent(s) at any time in the month of death or preceding 6 months, the parent(s) can be paid benefits beginning June 1986 through the month of death (see SI 02101.007).

An underpayment may be paid to a State or political subdivision with an interim assistance reimbursement (IAR) agreement (see SI 02101.004). IAR takes priority over issuance of an underpayment to a survivor.

In cases which there is no IAR, nor an eligible surviving parent(s) (or spouse), a disability determination can still be made for medicaid purposes upon request of a Medicaid agency. (This applies in States which SSA does Medicaid eligibility determinations). See question 21.

Follow DI 12597.030.C.11.e if no underpayment can be paid to any party. Send SSA-L8166-U2 with opening paragraph "This notice refers to your request for Zebley review." and refer to SI 02101.008 for sample notices for these situations. Also include Medicaid paragraph.

Question 58: Are there any special considerations for Zebley redetermination profiles?

Answer: No, at this time there are no special considerations for Zebley redetermination profiles. All Zebley cases will be coded with profile code 'Z'.

Question 59: On pipeline cases where FO has stated they cannot locate claimants, must the FO send an additional letter?

Answer: The FO should follow the process as outlined in SI 00501.515. The FO must make every effort possible to try and locate the individual including a personal contact (if practical). All efforts to locate the individual must be documented in the file on a SSA-5002 (Report of Contact).

Question 60: SI 02008.011 says all notices must be manually prepared by FOs. What about medical denials?

Answer: All medical denial notices will be prepared and released by the DDSs. The notice instructions for the DDSs are located in DI 32597.025 ff.

Question 61: What is FO procedure for closing-out late responders if good cause is not found. Does it have to be sent back to LS?

Answer: The procedure as outlined in DI 12597.010.B.ff should be followed.

Question 62: How will DDS notify FO to initiate current payment where medical development is expected to take more than 60 days?

Answer: The procedure as outlined in DI 32597.010.D.2. should be followed.

Question 63: What happens if we have a medical allowance, but we can't locate the person. Will they remain in suspense forever?

Answer: The FO must make every effort possible to try and locate the individual and process as per SI 00501.515. All efforts to locate must be fully documented on an SSA-5002 (Report of Contact). Reestablish the claim as a start date record and include the appropriate denial reason on the input (N17).

Question 64: Will CDRs be included in the first in first out approach or will this be delayed?

Answer: There will be no separation of cases, alerts will be released on a flow basis, first in first out.

Reminder Items

Screening

Be sure and follow procedures as outlined in DI 12597.020 when screening cases for class membership.

Be sure the screenout code on the screening sheet corresponds with the screenout reason on the non-class member notice.

Non-Class Member Notice

It has been brought to our attention that there are several cases in which the claimant was age 18 or over at the time of filing. The present non-class member notice (Ex. 8 DI 12597.095) does not cover this situation. We are preparing a teletype responding to this issue.

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This is the eleventh installment of the Childhood Disability Hotline Questions and Answers (Q & A). There are 12 questions organized under 10 topic headings in this transmittal.

Inquiries about these Q & A should be addressed to the RO Zebley coordinators. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf at (410) 965-9245.

Evaluation of Cardiac Impairment--Pacemaker in Place

1. Question: Could a child with a successfully operating pacemaker be considered to have a nonsevere impairment if no functional restrictions were imposed? (Atlanta, 5/13/92)

Answer:

Yes. If the child has a pacemaker in place and the evidence, medical and nonmedical, shows that the pacemaker has been successfully operating over the entire adjudicative period such that there has been no more than a slight or minimal limitation in the child's ability to function independently, appropriately, and effectively in an age-appropriate manner, a finding that the impairment is nonsevere would be appropriate.

When a pacemaker is inserted in a child with cardiac disease, the child usually is functioning at a reasonably normal level a month after insertion of the pacemaker if there is no other cardiac problem. Therefore, in cases where the pacemaker is inserted to control only the rate and rhythm of the child's heart, and the pacemaker has been ascertained as performing its expected role in keeping the rhythm under control, we would not generally expect the child's ability to function age-appropriately to be substantially reduced by the cardiac disease.

The insertion of pacemakers for cardiac disease in children is considered to be significantly functionally restrictive only if there is some other underlying cardiac condition that remains uncorrected by the insertion of the pacemaker and for which further surgery is anticipated or continuing medication is required. In such situations, the cardiac disease may fulfill the criteria of a listing-level impairment. In contrast, where a life-threatening cardiac condition is completely ameliorated by the insertion of a pacemaker, the 12-month durational requirement may or may not be met depending on the other circumstances involved.

Purchase of Pulmonary Function Tests--Asthma

2. Question: What is the policy concerning the purchase of [pulmonary function tests] PFTs in cases of asthma? Is this a last resort or should it be considered as essential part of documentation as in adults? (Atlanta, 5/13/92)

Answer:

Pulmonary function tests (PFTs) are not essential evidence in the documentation of asthma in childhood disability claims. Rather, childhood asthma should be documented by radiographic evidence of the disease process and evaluated on the basis of medical and other evidence as to the nature, frequency, intensity of the impairment and the response to treatment of the disease process.

However, where the history indicates recurrent, if not progressive disease, and clinical notes are unavailable from the treating sources or insufficient to evaluate the level of impairment, the purchase of PFTs may be appropriate where the claim cannot otherwise be favorably decided and the child is capable of performing reproducible forced expiratory maneuvers. (This capability usually occurs around age 6.) In such cases, the values in Listing 103.13, Table I, should be used in the evaluation of the claim, with a finding of medical equivalency to Listing 103.13 being possible if the PFTs showed the child's pulmonary function to meet the criteria in the table. Of course, if a finding of equivalency is not possible or the child is too young to perform reproducible forced expiratory maneuvers, evaluation should continue through the remaining steps of the childhood sequential evaluation process, giving full consideration to all of the evidence, medical and nonmedical, in determining the child's ability to independently, appropriately, and effectively engage in age-appropriate activities.

Seizure Disorders--3-Month Period of Observation

3. Question: Seizure policy dictates that once a child has started treatment for a seizure disorder, it is necessary to wait three months before a response to treatment may be measured. Policy, however, does not address the situation in which the child has been on seizure medication for a[n] extended period of time and the medication is subsequently changed or increased. Is it necessary in these cases to hold for three months to measure the response? (Atlanta, 5/13/92)

Answer:

In the situation described, it would not be necessary to postpone adjudication for 3 months to measure the response to a change in medication. The 3-month period of observation called for in Listings 111.02 and 111.03 applies to children with a new onset of seizures or who have never been under treatment for epilepsy. The observation period is used to determine the clinical response of a seizure disorder to anticonvulsant therapy. The clinical history, neurological examination, laboratory results and description of the child's response to drug therapy are used in considering the level of severity of the seizure disorder over a 12-month period. Consideration must also be given to any functional limitations imposed by the impairment and whether the level of severity of such functional limitations will last over a 12-month period. If the child has been treated for three or more months by a regular treating source or source of record prior to applying for disability benefits, it would not be necessary to require a 3-month observation period because the clinical evidence should be available to allow the adjudicator to reasonably anticipate the level of severity over a 12-month period.

Seizures do not have to be fully controlled by the 3-month mark for the adjudicator to be able to anticipate that the disorder will be controlled and not disabling for a 12-month period. However, as a general rule, if the child continues to have frequent seizures in spite of prescribed treatment during the 3-month observation period, or if the child demonstrates intolerance to the medication or develops significant adverse effects from anticonvulants over that period, it can reasonably be concluded that the child will not be satisfactorily controlled by anticonvulsant therapy within a 12-month period. The level of severity, as with adults, is judged on a case-by-case basis.

Notwithstanding the general principles enunciated above, where there is information in file which raises a question as to whether the impairment will continue for a 12-month period, that information must be evaluated to determine whether the duration requirement of the law is met.

Finally, even though the vast majority of individuals with epilepsy can be successfully treated and controlled with appropriate medication, there are certain forms of seizure disorders in children, such as mixed seizure disorders related to post-traumatic or congenital structural deficits of the brain, that may resist practically all attempts for adequate control. Again, each case will have to be evaluated on its own merits.

Functional Equivalence Example 3--Life-Sustaining Devices

4. Question: POMS DI 25215.015B. gives examples of impairments that are functionally equal to the listings. Example 3 lists: Daily need for life-sustaining device (e.g., mechanical ventilation at home or elsewhere, lasting or expected to last 12 months. The DDS' have raised the issue of how far can we carry the concept of "life-sustaining device?" The one example given is mechanical ventilation. The use of such a device would obviously result in severe functional restrictions for the child, and the cessation of use of such a medically necessary device would probably result in death. In determining functional equivalence, it is the consequences of an impairment or combination of impairments that makes an individual disabled. A reading of Regulation 416.926(a) clearly indicates the level of severity intended for functional equivalence. However, is there any concise criteria which can be used for determining if a particular device meets the necessary criteria. The DDS' have asked specifically if a pacemaker or insulin [pump or] nebulizer for asthma would meet the criteria. Although medication is clearly not a "device," a pacemaker is. Please clarify this issue. (Chicago, 3/25/91)

Answer:

First, you are correct in understanding that the word "device" in Program Operations Manual System (POMS) DI 25215.015B., Example 3 should be read literally. Example 3 does not refer to the use of medications or procedures used in medical treatment.

As we indicated in our response to Question No. 5 in Childhood Disability Hotline Questions and Answers (Q & A) Transmittal No. 2, issued May 15, 1991, we do not plan to construct a definitive list of medical devices that would be considered "life-sustaining" for the purposes of Example 3 because we could not ensure that such a list would be all-inclusive. However, some general guidelines for identifying such devices are:

- it performs a life-sustaining function for the user (i.e., it takes the place of the physical organ that would ordinarily perform the function), and
- it maintains a steady state with respect to the function of the organ, and
- it does not alter the user's underlying medical condition, and

- it requires frequent monitoring, checking, and maintenance to prevent complications (e.g., malfunction, leaking, bleeding, infection) and to ensure the proper continuity of functioning, and

- without the device the user would die relatively quickly.

Taken all together, these guidelines may help to identify a "life-sustaining device" under Example 3. However, the judgement of a qualified medical professional is needed to apply the guidelines in any particular case.

The intent of Example 3 is not simply that a child is dependent upon a device for physical well-being, but that the need for the device as well as the use of it impose functional limitations that are of listing-level severity. This is the case in the examples of "life-sustaining devices" provided in Q & A No. 2. Thus, a child who must use a mechanical ventilator is restricted not only by the effects of a severe underlying respiratory disease which limits his or her ability to breathe independently, but also by the necessity of being attached to the apparatus that performs the ventilatory function. A child who has a central venous catheter to facilitate chronic daily hyperalimentation is restricted not only by the effects of a gastrointestinal dysfunction so severe that normal feeding processes are inadequate to meet the child's nutritional needs, but also by the need to be connected to intravenous equipment that dispenses the required nutrients. A child who must undergo continuous ambulatory peritoneal dialysis is restricted not only by the effects of irreversible kidney damage or failure, but also by the frequent need to be attached to the dialysis equipment.

In contrast to the characteristics and functional limitations associated with the examples of "life-sustaining devices" in Q & A Transmittal No. 2, other devices (e.g., cranial shunt, pacemaker, insulin pump, nebulizer, home positive pressure machine) can be characterized as forms of intervention which may alleviate acute problems; which tend to control the anticipated chronic problems of a disease or disorder and, therefore, may improve the child's medical condition; and which, thereby, generally decrease the severity of functional restrictions experienced by the child. However, because each of these other devices does not "fit" one or more of the guidelines mentioned above, such examples do not constitute "life-sustaining devices" as intended by Example 3. For example, a cranial shunt in the case of hydrocephaly, or a pacemaker in the case of cardiac disease, once implanted does not require frequent monitoring, checking, and maintenance to

assure its proper functioning. The shunt or pacemaker functions unobtrusively and generally does not, of itself, interfere with age-appropriate activities. An insulin pump used in the treatment of diabetes or a nebulizer used in the treatment of cystic fibrosis does not take the place of a physical organ that ordinarily performs a specific function and is not needed to maintain a steady state with respect to the purpose of the organ. The removal of a home positive pressure machine, although it may worsen a patient's respiratory status, would not result relatively quickly in the patient's death.

Although many devices that children may use in their medical treatment are not "life-sustaining devices" according to Example 3, the use of these devices may still contribute to a finding of disability on the basis of functional equivalency or on an individualized functional assessment if the frequency and duration of a child's use of the device, in conjunction with all signs, symptoms, and laboratory findings, and other factors associated with the child's impairment(s), mean that the child's ability to function independently, appropriately, and effectively in an age-appropriate manner is substantially reduced.

Functional Equivalence Example 15--Microcephaly

5. Question: Are serial measurements of head circumference needed to evaluate for microcephaly under the functional equivalence example, or is one measurement sufficient? (Atlanta, 2/28/92)

Answer:

For purposes of evaluation under POMS DI 25215.015B., Example 15, microcephaly specifically refers to hereditary microcephaly or microcephaly due to other disorders affecting brain development (e.g., severe intrauterine or chronic neonatal infection; perinatal anoxia). In such situations, one head measurement is sufficient to establish functional equivalence to Listing 110.08 (the most appropriate listing for Example 15) where the evidence in file is sufficient to confirm the existence of an unusually small head and the medical evidence indicates that the type of microcephaly is one other than dominant autosomal inheritable microcephaly (a relatively rare form of microcephaly in which the head is unusually small but physical and mental functions are essentially normal). This is because microcephaly in which the head size is more than 3 standard deviations (SD) below the norm is universally accepted by the medical profession as

being most frequently associated with mental retardation, but may also be associated with abnormal physical findings which are usually of a severe nature.

6. Question: Must we obtain the head circumferences of parents and/or siblings for . . . functional equivalence example [15], as we do for short stature? (Atlanta, 2/28/92)

Answer:

No. Measurements of head circumferences of the parents and/or siblings of a child whose head circumference measurement is more than 3 SD below the norm would not be necessary. This is true where there is evidence of mental or physical limitations associated with the microcephaly as well as in those situations in which dominant autosomal inheritable microcephaly is suspected (family members may demonstrate unusually small head circumference measurements) but the child is essentially normal in all areas. In the former situation, where the evidence establishes functional consequences which can be related to the child's small head size, adjudication under example 15 is based on the impact of the microcephaly on the individual child's functioning. Similarly, in the latter situation, where the child is of normal intelligence and does not exhibit any functional limitations as a result of the small head size, it does not particularly matter whether or not other members of the family also have small heads.

Evaluation of Chronic Disorders--No Significant Functional Limitations

7. Question: We review cases with serious chronic illnesses such as sickle cell disease and cystic fibrosis where the child is not experiencing significant functional limitations. How should we evaluate these cases as we are reluctant to call them not severe, due to the nature of the impairment? We are concerned that parents will not understand why we are saying that their child who has been diagnosed with a serious illness but who at the time of adjudication has no significant functional limitations, is not severe. Please provide guidance in our assessment of these cases. POMS DI 25215.005 provides guidance in determining if a child has a severe impairment(s). If a very young child is currently experiencing only minimal functional limitations due to the condition, yet in all probability the child will experience greater limitations in the future, might this be a consideration in the overall assessment? (Chicago, 11/1/91)

Question: We need clarification of final regs concerning chronic disease diagnosed in early childhood (infancy). Two examples are hemoglobinopathy and cystic fibrosis, both of which can be diagnosed or tentatively diagnosed shortly after birth, and may have been diagnosed as a result of a routine screening procedure or family history, and not necessarily because of clinical manifestations. This is further compounded by the fact that when a certain condition is strongly suspected, definitive diagnosis cannot be made in very early infancy (e.g., hgbSF) especially if the child has had no significant manifestation of the disease prior to the filing date. Both of the examples (and there are others not mentioned) have a poor prognosis as the child matures. However, based on diagnosis, or tentative diagnosis, alone, how are we to consider these cases?

Proposed response by Atlanta--While certain diseases/ disorders are uniformly associated with a fatal outcome or significant mental retardation, others may have a wide spectrum of clinical severity which cannot be predicted on the basis of either the screening or diagnostic test. Examples of the former include Tay-Sachs Disease, Hurler Syndrome, and other uniformly fatal neurodegenerative illnesses which meet 110.08B and those nonprogressive disorders such as non-mosaic Down Syndrome (110.06) or other chromosomal abnormalities as non-mosaic Trisomy 13 and 18 (110.08A) where significant mental retardation is inevitable.

However when assessing claims of children affected with one of the latter disorders, it would be best to assess the claimant's current impairment because in many of these disorders, despite a confirmed diagnosis, the severity can vary and is not always predictable. Examples of these disorders which may be diagnosed before symptoms begin include Sickle Cell Anemia, Thalassemia, Cystic Fibrosis, Hemophilia and Muscular Dystrophy. While children with these disorders usually have progressive disease, it is not possible to predict the onset and progression of symptoms. In fact some of the children may have minimal impairments for years. If needed it would be possible to compile a more complete list of diseases in each category.

Finally, there are those disorders which are found on routine neonatal screening, such as PKU, Congenital Hypothyroidism, Galactosemia, and Congenital Adrenal Hyperplasia for which early diagnosis and treatment is usually effective in preventing the severe sequela of the untreated disorder. Obviously these would also be assessed on the severity of the current impairment. (Atlanta, 5/13/92)

Answer:

Atlanta's proposed response is essentially correct. To be found disabled, a child must have a medically determinable impairment(s) that substantially reduces his or her ability to function independently, appropriately, and effectively in an age-appropriate manner. As Atlanta points out, Listings 110.08 and 110.06 take into consideration the fact that there are impairments which can be diagnosed at or shortly after birth which are uniformly associated with a fatal outcome or significant mental retardation. Because of the known course of the disease and/or the ability to predict the effects on function within a specified timeframe such impairments are considered disabling, i.e., of listing-level severity, on the basis of a positive diagnosis. Examples of such conditions are Tay-Sachs, non-mosaic Down syndrome, and anencephaly. In contrast, other impairments, e.g., mosaic Down syndrome, Sickle cell anemia, cystic fibrosis, can also be diagnosed or tentatively diagnosed at birth, but are progressive in nature. While such impairments can substantially reduce the child's ability to function over time, the degree of impairment of function is not the same in all children with the same diagnosis, nor even in two children of the same age with the same diagnosis. Therefore, even though a positive diagnosis may be made at birth or shortly after birth, the evaluation of these types of impairments is predicated not upon the diagnosis but, rather, on the consideration of the disabling functional consequences of the impairment(s). Adjudication follows the sequential evaluation for children to determine the severity of the impairment and, if appropriate, whether the impairment is of listing-level severity or, if not, whether the child's functional limitations are severe enough to be of comparable severity to those which would disable an adult.

Finally, while we share with Chicago the concern that our notices not understate the seriousness of a child's impairment(s), we would remind Chicago that our notices do not say that a child's impairment is "not severe." Rather, they advise that the severity of the child's impairment is "not disabling under our rules. . . . because it does not limit [the child] from doing things that other children [his or her] age normally can do to the extent required by our rules."

School Absences--Not Attributable to Medically Determinable Impairment

8. Question: How should we handle cases where a child is absent [from school] frequently but the absences are not attributable to a medically determinable impairment? For

example, if a child is absent 45 of 100 class days, but the file shows that the absences are not due to any illness, can the school absences be dismissed as not indicative of a medically determinable impairment? If the child is doing poorly academically due to frequent absences, can we still make a finding of "no medically determinable impairment" if there is nothing else in file to which we can attribute the poor academic performance? If not, how would the cognitive domain be rated?

Case example [SANITIZED]: While this case is still being developed for other issues, we [are forwarding] . . . a photocopy of the case to illustrate the school attendance issue. (New York, 7/23/91)

Answer:

If the school absences are not due to a medically determinable physical or mental impairment(s), any adverse effects attributable to the school absences cannot be considered when evaluating the claim. What appears to be an underlying, but unasked, question is whether school absences themselves constitute a medically determinable impairment. The answer to this question is "No". School absences, either alone or in combination with poor academic performance which can be attributed to the absences, do not constitute a medically determinable impairment. Nor should poor academic performance serve as a basis for assessing a limitation in cognitive functioning where school absences and/or poor academic performance are not related to a medically determinable impairment(s).

Permanent (MINE) Diaries for Children

9. Question: Can we use permanent diaries on children? 12.05C?, 102.02?, 102.08?. etc. (Kansas City, 4/5/91)

Answer:

Yes. The criteria for establishing "medical impairment not expected" (MINE) criteria, which are contained in POMS DI 26525, were issued in POMS Chapter 265, Transmittal No. 6 subsequent to Kansas City's question. They are being reiterated here for the record. POMS DI 26525.040 explains that the MINE diary may now be set for children when a MINE criterion applies. Thus, a 7-year MINE diary may be set for children whose case facts correspond to those of a MINE criterion in DI 26525.045B.2. DI 26525.050B.2. further

explains that a MINE diary may be set whenever an individual of any age has a chronic or progressive impairment or combination of impairments.

Determining Representative Payee--Child in a Residential Facility

10. Question: If a child is found to be currently disabled, either on a new application or readjudication, and the child is in a residential facility (but still eligible for SSI), the cost of which is being paid by HRS, can the facility be made the child's payee and use the monthly benefits to cover some of the costs of the child's care, thereby lessening HRS's expenditures?

Proposed response by Atlanta: Payee determinations must be made on an individual basis. All potential candidates must be considered and the best candidate selected. Residential facilities can be made payee, if there is not a more suitable option. Payees are required to use the benefits first for current living expenses (including the cost of a child's care). (Atlanta, 11/5/91)

Answer:

The proposed response by Atlanta is essentially correct as far as it goes. In appointing a representative payee for a minor child, SSA selects that person, agency, organization or institution that will best serve the interest of the child. Regulation 416.621 and POMS GN 00502.105 provide a guide for selecting a representative payee by order of preference. In general, for minor children the order of preference indicates that parents, legal guardians and relatives with custody are highest on the list, with custodial institutions at the bottom. In making the selection, SSA will consider who is in the best position to know of the child's needs and to see that these needs are met. Since the benefits payable on behalf of the child belong to the child, to be used for the child's care and maintenance, we consider that benefits have been expended properly if they are used for current needs such as food, shelter, clothing, medical care and personal comfort items.

Under our regulations, a care-providing facility (i.e., a State institution or residential facility) which has been appointed representative payee, can allot a reasonable share of the benefits for the customary charges for care, unless the maintenance charges are not legally assessable under State law, or under a Court decision or order (i.e., a State entity may have a legal obligation to care for the individual

without charging for current maintenance). If the charges are legally assessable, using benefits for current maintenance needs is permissible under the regulations.

Recoupment of Prior Costs by Department of Health and Rehabilitative Services--Child Awarded Retroactive Benefits

11. Question: If a child is allowed retroactive benefits, can the [Department of Health and Rehabilitative Services] HRS recoup any of their prior costs directly from SSA or must HRS negotiate with the individual beneficiaries?

EXAMPLE: A child is allowed on a continuous period of disability back to 1984. From 1985 to 1987 the child was in foster care (or a private mental health residential facility). HRS paid all of the child's support costs during that two year period. Can HRS be directly reimbursed by SSA for these costs from the retroactive payments for those years?

Proposed response by Atlanta: SSA can not reimburse HRS for prior years of support. The only provision for SSA's redirecting retroactive SSI benefits is with Interim Assistance Reimbursement Agreements. (Atlanta, 11/5/91)

Answer:

Atlanta's proposed response is essentially correct. The general applications and policies and procedures outlined in POMS GN00204.001ff. are equally applicable to cases readjudicated under the terms of the Stipulation and Order in Zebley. In Zebley cases, once a response is received from the claimant and class membership is established, the field office will interview the proper applicant and begin development of medical and nonmedical sources of information. Payment of benefits will be made to the person or organization whose selection as payee is in effect at the time of payment (see POMS GN 00603.070.)

For payee purposes, if the claimant is now over age 18, it is usually assumed that there is no need for a representative payee unless there is information to the contrary. In such an event, the guides for order of preference in selecting a representative payee in regulation section 416.621 should be applied. Any payments made to a representative payee, where one is selected, are to be used for the claimant's current needs and should never be used for other expenses, such as a past debt, while current needs are unmet. SSA will, however, honor a past debt when it involves an IRS levy for income

taxes, a garnishment of wages under section 459 of the Act, and refunding an overpayment of title II or title XVI benefits. Claims for other debts, such as reimbursement for care and services provided by a former family member, must be handled outside of the SSA process.

Where an entity, such as HRS in the example presented, has provided support, the agency may seek reimbursement for past support through the interim assistance reimbursement (IAR) process. Briefly, this process requires State agencies to comply with the IAR rules set forth at regulations section 416.1901ff. These rules require States to enter into an agreement with the Secretary of the Department of Health and Human Services (DHHS). To be covered under the IAR process, the assistance provided cannot include Federal funds. Since many State foster care programs are administered under title IV of the Social Security Act and involve Federal matching funds, such payments do not qualify for IAR.

If, however, HRS receives no Federal assistance for the foster care payments it provides to disabled children and has entered into an IAR agreement with DHHS, HRS foster care payments may qualify for IAR. However, an authorization must already have been given or HRS first must obtain an authorization agreement from the claimant or his or her representative. Since there is no Federal requirement mandating a claimant to execute IAR authorizations, the opportunity for HRS to be reimbursed through IAR may be limited.

This is the tenth installment of the Childhood Disability Hotline Questions and Answers (Q & A). There are five questions organized under five topic headings in this transmittal.

Inquiries about these Q & A should be addressed to the RO Zebley coordinators. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf at (410) 965-9245.

Noncompliance with Ritalin Treatment

1. Question: How should issues of noncompliance with Ritalin treatment be handled? (Atlanta, 3/8/91)

Answer:

Ritalin (methylphenidate hydrochloride) is a mild central nervous system stimulant. In children, Ritalin is most commonly prescribed for Attention Deficit Hyperactivity Disorder (ADHD) although it can also be prescribed for narcolepsy, which may occur in older children and adolescents. As in ADHD, the use of Ritalin may or may not be effective in the control of narcolepsy and may cause undesirable side effects in some children. Because the incidence of narcolepsy in the child population is relatively small with, by far, the most common use of Ritalin being for ADHD, the particulars of this response focus on ADHD. However, the failure-to-follow-prescribed-treatment principles described below apply equally when Ritalin is prescribed for narcolepsy and, for that matter, for any prescribed treatment for any impairment.

Ritalin has a "paradoxical effect" on a significant number of hyperactive children--instead of stimulating them, it calms them. Although its benefits for many children with ADHD are well-established, with decreases in inattention, impulsiveness, and hyperactivity, some children are not helped at all, and for some children undesirable side effects have been reported, including nervousness, insomnia, loss of appetite, and weight-loss. In certain quarters, for example, with a growing number of physicians, it is thought Ritalin is over-prescribed, while in others, such as the schools, there may be a feeling that it is under-prescribed. Some parents resist any efforts to place their children on Ritalin or any other psychotropic medication.

Despite continued controversy over the practice of prescribing Ritalin for ADHD, it is currently considered by many physicians to be the drug of choice in treatment of this disorder. An optimum treatment

plan would also include counselling for the child and parents, as well as appropriate therapy for any associated learning problems.

Because of the benefits of Ritalin for many children with ADHD, there is a potential failure to follow prescribed treatment issue if Ritalin is prescribed but the claimant is not taking the medication. However, there are several factors that must be very carefully considered before making a determination based on failure to follow prescribed treatment in any childhood case, and especially one in which Ritalin is the treatment in question. (The relevant procedures are outlined in Program Operations Manual System (POMS) DI 23010.005ff.)

23010.030

- It must be established that without the treatment the impairment is disabling and meets the duration requirement.

- If the impairment is disabling, the prescribed treatment must be clearly expected to restore the child's ability to function independently, appropriately, and effectively in an age-appropriate manner, to the extent that the impairment would no longer be disabling. As noted above, this is by no means a given with Ritalin in ADHD cases. Some children are not helped at all, or not very much. To meet this "clear expectation" requirement, therefore, there would have to have been an actual trial on Ritalin, and the evidence would have to show that the Ritalin actually restored the child's ability to function to the point where the impairment was not disabling. This will require careful evaluation of functional evidence, because the effectiveness of Ritalin is monitored only by direct observation of the behavioral response, rather than by measurements of blood serum levels. Also, because Ritalin may be only part of a treatment regime, it would be critical to establish whether the Ritalin by itself would be expected to restore the child's ability to function (unless, of course, the claimant is not complying with the rest of the prescribed treatment as well).

- If the current prescribed treatment is clearly expected to restore the ability to function, the evidence must show there has been a refusal to follow the prescribed treatment, and that there is no good cause for the refusal. As noted above, Ritalin causes undesirable side effects for some

children, so in addition to the good cause justifications outlined in POMS DI 23010.005A.3., a child's parent might have good cause to discontinue the child's Ritalin treatment because of such side effects. This may seem unlikely in a case where Ritalin results in a major reduction of disabling ADHD symptoms, but it must be remembered that untreated ADHD is rarely life-threatening, and the side effects may be very distressing to the child and his or her parents. (Of course, it is possible that the side effects themselves could be disabling or that the child could have other medical conditions precluding the use of Ritalin. In these cases, the treatment would not restore the child's ability to function and there would be no issue of the failure to follow treatment.) On the other hand, we would not find good cause for not following prescribed treatment solely because a parent does not like the idea of placing his or her child on a psychotropic medication such as Ritalin. Remember, though, that before even considering good cause we must have established that the Ritalin is clearly expected to restore the child's ability to function independently, appropriately and effectively in an age-appropriate manner to the extent that the child would not be disabled. This would require that at some point the child was taking the medication.

- If there is no good cause for the refusal, we must make sure the child's parent or other primary caregiver is fully aware of the possible consequences of failure to follow prescribed treatment without good cause. Claimant contact procedures are given in POMS DI 23010.010. We would only add the reminder that, in childhood cases, it is especially important to make every effort to assist the claimant and his or her parent or guardian in understanding what is required.

- Finally, we must remember that a child is not fully responsible for his or her failure to comply with prescribed treatment. If there is a clear failure issue, without good cause, and the child's primary caregiver is unwilling to ensure prescribed treatment will be followed, we must consider whether a new payee should be developed or the case should be referred to an appropriate social agency for assistance, per POMS

DI 23010.020. (If the child is a Zebley class member, see POMS DI 12597.030C.6. and C.7. and DI 32597.010B.13. and B.14.)

If all the appropriate procedures have been followed, and all of the conditions outlined above are met, a denial based on failure to follow prescribed Ritalin treatment would be appropriate.

Acceptable Language for IFA for Older Adolscents (Child 16-18)

2. Question: What is acceptable language for the IFA age 16 to 18? Can the comments be placed in the same terms we use for adults (i.e., stand/walk for 6 hours and lift/carry 20 pounds? (Atlanta, 3/8/91)

Answer:

In the individualized functional assessment (IFA) for older adolescents aged 16 to 18, for the most part it is not appropriate or necessary to use the same terms we use to describe functioning in adults. This is because the kind of assessment implied in the question encompasses the adolescent's capacity for work throughout the exertional spectrum (i.e., sedentary to very heavy work) and, thus, exceeds the requirements of the determination used for an older adolescent.

In regulation § 416.924 and POMS DI 25201.001C.2., "comparable severity" is defined for an older adolescent in terms of a limitation in the person's ability to function independently, appropriately, and effectively in an age-appropriate manner and, more particularly, as a substantial reduction of the adolescent's ability to acquire the skills needed to assume the roles reasonably expected of an adult. Thus, according to regulation § 416.924e(d)(1) and POMS DI 25220.025B.3. and DI 25220.020C.5., age-appropriate functioning for children aged 16 to 18 is the same as that for 18-year-olds and includes the ability to do work-related activities--specifically, the basic physical activities of at least sedentary work and the basic mental activities of at least unskilled work. As explained in regulation § 416.924e(d)(4) and POMS DI 25220.025C.3., if an older adolescent manifests a substantial loss or deficit of ability to do these physical or mental activities, we would find him or her to be disabled.

As stated in POMS DI 25220.010B.3., we consider the functioning of older adolescents by examining their performance in the functional domains and behaviors and their ability to engage in work-related functions/behaviors. POMS DI 25220.025B.3.d. further explains that we evaluate the functioning of older adolescents in terms of their ability to perform mental and physical functions in the workplace by (1) using information concerning the adolescent's cognitive, communicative, motor, social, and personal/behavioral functioning and concentration, persistence, and pace in age-appropriate tasks, and (2) evaluating the adolescent's functioning in age-appropriate contexts such as school, vocational programs, part-time or full-time work, and organized activities. Once we have gathered information about an older adolescent's daily activities, we can organize the information (as we do for younger children) in terms of the functional domains and behaviors, so that we can create a clear profile of the kinds of things he or she can and cannot do.

In evaluating adolescents, we do not use the adult sequential steps 4 and 5, we do not consider the adolescent's capacity for past work or other work, and, therefore, we do not need to reach the kind of conclusions appropriate to a residual functional capacity assessment, as noted in Atlanta's question. Rather, the profile we draw of the adolescent's motor abilities and capacity for concentration, persistence, and pace must enable us to determine only if he or she can perform the basic physical demands of at least sedentary work. That conclusion can be stated in terms of the specific physical requirements of sedentary work, e.g., capacity to sit for most of the work day, with occasional standing and walking, to lift and carry items weighing up to 10 pounds., etc. Similarly, the profile we draw of the adolescent's cognitive, social, and personal/behavioral functioning, as well as the capacity for concentration, persistence, and pace, must enable us to determine if he or she can perform the basic mental demands of at least unskilled work. That conclusion can be stated in terms of the specific mental requirements of unskilled work, e.g., capacity to understand, carry out, and remember simple instructions, to respond appropriately to supervision and peers, etc.

These are thc terms, then, that we use to describe and evaluate an older adolescent's functional profile. Most importantly, it is essential that the disability

determination we make based on that profile be the same as the determination that would be made for an 18-year-old adult having the same medically determined functional limitations.

Evaluation of Disability in a Child With a Not-Severe Phyiscal Impairment and No Allegation of a Mental Impairment

3. Question: Give a brief discussion of how to evaluate childhood cases where only a physical impairment has been alleged, and the medical evidence rules out a severe physical impairment. In a cited example, the child, age 16, has not returned to school allegedly because of a back condition. Would this behavior (not going back to school) alone generate the need to develop for a mental impairment? (Chicago, 9/19/91)

Answer:

Your question does not tell us the reasons the child has not returned to school, and such information is essential in determining whether the impairment is, in fact, not severe. Is the child having an emotional reaction to the impairment(s) or its effects? Is the child in pain? When determining whether the impairment imposes no more than slight or minimal limitations, such factors must be considered. Limitations caused by emotional reactions can be assessed without establishing that the child has a mental impairment. Symptoms, such as pain (assuming that there is a medically determinable impairment which could reasonably be expected to cause them), must be considered in determining whether the impairment is severe and, if so, whether it is disabling (see regulations § 416.929; POMS DI 24515.060). If the effects of the impairment(s) and its related symptoms cause more than a slight or minimal limitation in the child's overall ability to function, the impairment(s) must be determined to be severe even though the child does not have significant physical limitations.

However, if only a physical impairment(s) is alleged, and the medical evidence from both "acceptable medical sources," "other sources" and other evidence in file shows no indication of a mental impairment and no more than slight or minimal limitations in the child's ability to engage in age-appropriate activities, the case should be denied as the impairment is not severe.

Zebley Readjudication Cases-Claimant Declines to Submit Current Evidence or Attend A Consultative Examination

Question: Are any special procedures required for processing readjudication cases where the claimant states that they do not wish to submit current evidence, including meeting a C/E, and requests a decision on their previously denied claim using only available evidence of record? Specifically, can the DDS curtail current development in this situation and go ahead and request the prior file? If so, is a signed statement from the claimant required or will a report of contact suffice? Atlanta, 1/6/92)

Answer:

The procedures outlined in POMS DI 32597.010.C.1.-C.3. and DI 32597.010.D.1.-D.5. should be followed in processing these cases. These procedures state that the disability determination services (DDS) should first determine if onset can be established as of the earliest reopened application date. If it cannot be, then the adjudicator should attempt to find current disability and try to apply the presumption. However, if current disability cannot be established, or the presumption cannot be applied, the DDS must secure the prior folder.

The processing of these cases is analagous to the processing of pipeline cases:

- If updated information is not available, or no authorizations are in file (or there are no sources to contact), secure the prior folder.
- After the prior folder is secured, review the evidence in file using the new regulation.
- If, based on the evidence in file, the DDS can determine that the individual is not disabled, input the appropriate denial regulation basis code.
- If the DDS is unable to make a decision because the evidence in file is insufficient, the DDS should deny the case based on basis code N-36, (Insufficient Evidence).

- o If no prior folders exist, no retroactive medical evidence of record is available, and current disability cannot be established, prepare a denial (DI 32597.010.D.6.b.).

- o If the DDS is able to make a favorable determination based on the evidence currently in file, document and record this determination and forward the folder to the field office for nonmedical development.

Failure to Cooperate-Evidence Insufficient for Medically-Based Decision

5. Question: When the Zebley responder and/or representative fails to cooperate with the DDS or the DO, and the DDS determines that evidence in the current file or available prior file is insufficient for a medically-based decision, may the DDS deny the claim for failure to cooperate without requesting the (other) prior files? This procedure would seem comparable to the DO's N17 denials of noncooperative responders whose files contain no medical evidence, i.e., the noncooperative responder would be accorded a review of any initially-available medical evidence but further pursuit of the claim would require the claimant's cooperation. (Atlanta, 2/28/92)

Answer:

The procedures as outlined in DI 32597.010B.13. and B.14. must be followed before a failure to cooperate determination is rendered. The DDS is responsible for making every effort to provide assistance to the child, his or her parents, guardians or other person acting on the child's behalf, and to document the case record as to the child's medical history and functioning. The DDS must make special efforts to locate an adult person responsible for the child's care, including an attempt to make a personal contact with the child's family or custodian. It is not necessary to secure the prior file in these situations. The court order clearly states, "Any class member who elects readjudication . . . will have his claim readjudicated in accordance with the Social Security Act, regulations, policies and procedures, including those requiring a claimant to cooperate with and provide information needed by the Social Security Administration to adjudicate his claim." However, while a parent's cooperation is required, for example, in providing us with evidence in their possession, the names of sources and written

permission to contact these sources, we do not generally require parents to obtain and bring evidence from other sources to us. Further, a parent's inability to obtain evidence would not be considered to be noncooperation.

week of 11/2/92

This is the ninth installment of the Childhood Disability Hotline Questions and Answers (Q & A). There are two questions organized under one topic heading in this transmittal.

Inquiries about these Q & A should be addressed to the RO Zebley coordinators. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf at (410) 965-9245.

Effects of Medication

Question: In the recently issued Childhood Questions and Answers No. 2, we have a question about the answer to question No. 3. Is the "equivalence" referred to in the response functional equivalence or medical equivalence? (Atlanta, 6/5/91)

Question: We need guidance on how to assess severity in various domains in cases involving chronic illness, e.g., nephrotic syndrome. In many of these cases the child's symptoms are minimized by medication. Although the impairment is severe because of the medical facts, there are usually no limitations described or only minimal limitations because of the success of the medication. When the limitations result in all domains being rated as less than moderate should the impairment be considered not severe? (Dallas, 5/6/91)

Answer:

In Childhood Disability Hotline Question and Answer (Q & A) Transmittal No. 2, Question 3, we stated that nephrotic syndrome with steroid dependence is equivalent in severity to Listing 101.02B, Juvenile Rheumatoid Arthritis (JRA) with steroid dependence. The concept of steroid dependence as a determinant of listing-level severity in JRA, as expressed in Listing 101.02B, is predicated on the holding at the time the listing was promulgated that the fact that steroids were being used to treat the JRA, and the recognized adverse effects of prolonged use of steroids (growth inhibition, profound adverse metabolic dysfunction, cataract formation and vulnerability to unusually severe complications of common childhood illnesses such as varicella), was indicative of JRA of listing-level severity without any further requirement that the manifestations of the impairment be documented. Since the introduction of the JRA listing in March 1977, advances in the treatment of JRA and in the administration of steroids for JRA and other diseases have led to questions about the current significance of steroid dependency in JRA. While we are reviewing this issue, Listing 101.02B should continue to be used for cases involving JRA.

The continued use of Listing 101.02B where JRA is involved does not mean, however, that steroid dependence, in and of itself, is determinative of disability for other impairments. Rather, where JRA is not involved, each case should be evaluated on its own merits, taking into consideration the severity of the underlying impairment or combination of impairments, the functional consequences of the impairment and of any adverse effects of treatment for the impairment(s). The fact that a child is dependent on steroids, or any drug, for the control of the adverse effects of an impairment is, in and of itself, insufficient to find disability. Thus, a child with a severe medically determinable impairment, such as nephrotic syndrome, who is being treated with steroids and is found to be steroid dependent, may or may not be determined to be disabled. Rather, the finding of disability would be based on the severity of the underlying impairment or combination of impairments, the functional consequences of the impairment and of any adverse effects due to the treatment with steroids.

In our response to Childhood Disability Hotline Q & A Transmittal No. 2, Question No. 3, we assumed that the manifestations of the nephrotic syndrome (proteinuria, hypoproteinemia, hyperlipidemia (hypercholesterolemia), and edema) were controlled by steroids, recurred when steroids were withdrawn, but the steroid treatment itself resulted in unspecified disabling adverse side-effects which were medically equivalent to listing-level severity. Therefore, in this instance, the determination of disability was on the basis of medical equivalence to Listing 101.02B. In contrast, a finding of functional equivalence would be appropriate where the long-term use of steroids had produced adverse side-effects resulting in limitation of function at listing-level severity in one or more body systems (e.g., musculoskeletal, visual). Functional equivalence can be found on the basis of evidence of functioning, medical evidence, or a combination of both. Medical evidence will be a basis for establishing functional equivalence rather than medical equivalence when the symptoms, medical signs and laboratory findings establish that the functional consequences of the child's impairment(s) are similar, in terms of their impact on the child's ability to achieve developmental milestones or perform age-appropriate activities, to the functional consequences of a listed impairment. This is clearly demonstrated by the examples in Program Operations Manual System (POMS) DI 25215.015B., some of which are stated solely in terms of medical findings. If there are no

adverse side-effects, or the severity of the side-effects are not medically or functionally at listing-level, and there are no other limitations from the impairment at listing-level severity, then equivalence to Listing 101.02B cannot be found and evaluation would proceed to consideration of the child's functioning through the preparation of an individualized functional assessment.

In response to the question from the Dallas Region, as discussed in POMS DI 25220.020C.4., a moderate limitation is one that is more than mild, but less than marked. An impairment or combination of impairments is not severe if it causes no more than a slight or minimal limitation in a child's ability to function in an age-appropriate manner. Hence, it is possible for a child to have an impairment(s), e.g., a chronic illness such as nephrotic syndrome, that requires medical intervention and/or monitoring, but which is not severe according to the regulations. This can occur if the child's condition(s) is so improved by medication that he or she experiences no limitations or only slight or minimal limitations resulting from the condition(s) (including consideration of any side-effects of the medication itself). Thus, if the combined effect of all impairment-related limitations in all domains or behaviors are rated as less than "moderate," i.e., are no more than slight or minimal, the child's impairment(s) should be considered not severe.

[1] From: ||childhood hotline at ~CO 8/5/92 10:37AM (1209 bytes: 15 ln)
To: FRED L. CRAWFORD, John Snee at ~S6A, Helene Weintraub, ||ATL ORC at ~~ATLANTA, ||BOS ORC at ~~BOSTON, ||CHI ORC at ~S2D5, ||childhood hotline, ||DAL ORC at ~S2D6, ||DEN ORC at ~~DENVER, ||KC ORC at ~~KC, ||NY ORC at ~~NY, ||OIO DRDD DDB at ~s2ECB, ||PHI ORC at ~~PHILADELPHIA, ||S3C, ||S3C2, ||S3C3, ||SEA ORC at ~~SEATTLE, ||SF ORC at ~~SF, |||S3GP OPPE at ~S3G
Receipt Requested
Subject: Childhood Disability Hotline Q & A No. 8
---------- Message Contents ----------

This is the eighth installment of the Childhood Disability Hotline Questions and Answers (Q & A). There are four questions organized under three topic headings in this transmittal.

Please provide copies to DPB, ROPIR and DQB. The DPB should provide copies to each DDS as soon as possible.

Inquiries about these Q & A should be addressed to the RO Zebley coordinators. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf, at (410) 965-9245

Please see attached Wordperfect file 5.0 named FINAL.QA8.

This is the eighth installment of the Childhood Disability Hotline Questions and Answers (Q & A). There are four questions organized under three topic headings in this transmittal.

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IQ Scores

1. Question: Central Office (CO) stated in 1989 that the results of the Stanford-Binet Fourth Edition (S-B IV) were acceptable for program purposes. However, CO stated that only the Test Composite Score could be used. Is this guidance still applicable? (Atlanta, 12/20/90)

   Question: In evaluating the results of the WISC-R and WAIS-R, we usually use the lowest of the verbal, performance, or full-scale scores. We were previously advised that, when using the results of the Stanford-Binet, fourth edition, contained in MER, only the composite should be used when evaluating under listings 112.05 (memo from OD to the Dallas region dated 9/20/89). Since this memo precedes the revised child regulations and revised child mental listing, we would like to know if this guidance is still applicable. (New York, 5/21/91)

   Answer:

   On September 28, 1989, the Office of Disability issued a memorandum providing policy guidance on the S-B IV. We assume that the questions from Atlanta and New York are in reference to this memorandum.

   The guidance in the memorandum is still relevant. Only the Composite Score, not the individual category Age Scores, is to be used where the listings require an IQ value.

POMS Instructions-Underpayment Due; Claimant Deceased

2. Question: POMS DI 32597.010.B11 instructs the DDS to follow existing procedures (cross-referenced to DI 23510.001C) when the claimant is deceased. However, the existing DDS procedure has not been updated since the Basic transmittal in 1/86 and does not reflect the current policy which permits payment of an underpayment to a surviving parent beginning June 1986. This discrepancy could lead the DDS to erroneously conclude that a medical decision is not necessary in these

cases. The cross-referenced procedure is also material for DDS processing of new initial DC claims without Zebley involvement. When will the DDS POMS be updated to reflect the correct policy? (The parallel FO procedures in DI 11055.050A and DI 12597.030C.11 are correct.) (San Francisco, 12/26/91)

Answer:

We appreciate San Francisco's pointing out this discrepancy. We originally prepared an update to POMS DI 23510.001C some time ago, but were unable to follow through with our plans because of the POMS moratorium in effect at the time. Since then the proposed changes to POMS DI 23510.001C have been added to a larger package. This larger package is currently being readied for preliminary review by the Office of Management Directives. We expect that, barring major changes, the final transmittal will be issued in September 1992.

Citation of Errors-Regional Medical Consultant Disagrees With the DDS's IFA Rating

3. Question: If the regional medical consultant (RMC) disagrees with the DDS's IFA rating, must the disagreement be substantive (not judgmental) before the RMC cites an error? Can "substantive disagreement" be defined? (New York, 5/17/91)

Answer:

A substantive disagreement is one that calls into question the accuracy of the disability determination (the decision to allow or deny). This can occur when either (1) there is insufficient documentation to support the DDS determination (a group I documentation deficiency) or (2) the documentation is complete and supports a different determination than that made by the DDS (a group I decisional deficiency). In order to record a group I deficiency, the quality reviewer cannot simply disagree with the DDS. Instead, the quality reviewer must identify a DDS action or decision which is clearly contrary to the documentation requirements and/or evaluation guidelines prescribed in published disability program policy and procedures. Such a deficiency finding must be clearly and pursuasively rationalized in the SSA-1774-U5 (Request For Corrective Action) return to the DDS. The SSA-1774-U5 should cite the applicable references to published program policy and/or procedures to support the deficiency finding.

The quality review instructions for title XVI childhood disability cases define two deficiency situations involving IFAs as group I deficiencies. These two deficiencies are substantive since they require either a reversal of the DDS determination or further medical development by the DDS before a determination is possible. They are defined as follows:

INCORRECT IFA--The case file contains sufficient documentation to support an opposite IFA determination; i.e., comparable severity instead of no comparable severity or vice versa.

UNDOCUMENTED IFA--One or more of the elements of the IFA (POMS DI 25220.020D) are not documented in the file; i.e., there is not sufficient evidence to support the IFA description(s) of or conclusions about functional limitations, and the undocumented element is material to the IFA determination on comparable severity.

Quality review deficiencies are not cited by RMC's, but by the quality reviewer in the disability quality branch (DQB). Deficiencies involving medical issues, however, require RMC input or signoff. The RMC provides the quality reviewer with medical input as to the sufficiency of the medical evidence and the level of medical severity.

Using RMC input in conjunction with medical and nonmedical evidence about an individual's impairment, the quality reviewer determines whether the DDS action or decision is correct or clearly contrary to the documentation requirements and/or evaluation guidelines prescribed in published disability program policy and procedures. An IFA decisional deficiency should never be a judgment, but a finding that the DDS' IFA determination is clearly contradicted by evidence in file.

As a point of information, it should be noted that current quality review policy for title XVI childhood cases mandates a group I documentation deficiency whenever there is a disagreement between the DQB and the DDS as to the sufficiency of the evidence in file. This means that the probability of reversal rule as defined in DI 30005.110B.2 does not apply to these cases and that all documentation deficiencies are returned to the DDS for development. However, all group I deficiencies cited and returned in title XVI childhood disability quality assurance sample cases are currently being excluded from the calculation of DDS performance accuracy.

This is the seventh installment of the Childhood Disability Hotline Questions and Answers (Q & A). There are four questions organized under four topic headings in this transmittal.

Inquiries about these Q & A should be addressed to the RO Zebley coordinators. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf, at FTS 625-9245.

Rating of Restrictions Associated With Mental Retardation

1. We are seeing several cases with valid IQs in the 60s and no additional physical or mental impairment. We know that cognition would be rated as marked. Since some individuals with mental retardation also experience limitations in other domains, e.g., social and personal/behavior, should these limitations be rated? If we are to rate these limitations in these other domains is there a problem with double weighting? (Dallas, 5/6/91)

   Answer:

   The answer to the first question is Yes. The answer to the second is No.

   In order to fully understand these responses, a distinction must be made between the process of establishing that a child has a medically determinable physical or mental impairment and the process of deciding how that impairment impacts on the child's ability to function in an age-appropriate manner. It is also helpful to examine the structure of Listing 112.05.

   A diagnosis of mental retardation cannot be based solely on IQ scores. The capsule definition of Listing 112.05, which is based on the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition-Revised (DSM-III-R), indicates that mental retardation is characterized by significantly subaverage general intellectual functioning with deficits in adaptive functioning. Thus, the medical evidence in file must substantiate the existence of both parts of the capsule definition before a diagnosis of mental retardation can be established.

   As outlined in section 112.00C of the childhood mental listings, the severity of a mental impairment is measured according to the functional limitations it imposes. The severity criteria of most of the childhood mental listings

are contained in paragraph B of these listings. Listing 112.05 is a little different. Its severity criteria are embedded within the six individual paragraphs of the listing.

The severity requirements in paragraph E of Listing 112.05 are based on a combination of a "marked" limitation in cognitive functioning, i.e., a valid verbal, performance or full scale IQ of 60 through 70, and a "marked" limitation in one of the other functional domains, i.e., a marked impairment in motor development or social functioning, if the child is aged 1 to 3; or a marked impairment in social functioning, personal/behavioral functioning, or concentration, persistence, and pace, if the child is aged 3 to 18.

We do not consider the assessment of these other domains to be double weighting. The DSM III-R points out that the level of adaptive functioning in persons with mental retardation varies and that "it is influenced by personality characteristics, motivation, education, and vocational opportunities." Thus, paragraph E requires that the limitations from the mental retardation be demonstrated in the ways discussed above. These severity requirements are consistent with those in the other childhood mental listings.

One other point. If a child has a severe impairment that does not meet or equal the severity of any listed impairment, the evaluation process does not stop at the meets/equals step. An individualized functional assessment must be prepared to determine if the limitations imposed by the child's impairments are nevertheless comparable in severity to an impairment(s) that would disable an adult. In preparing this assessment in mental retardation cases, we do not consider the rating of limitations in domains outside the cognitive area to be double weighting. This is because Regulation 416.924c directs us to consider the limitations that the impairment actually imposes in each functional area, as well as how a limitation in one functional domain affects the child's functioning in other domains. In short, the issue is not one of double weighting, but simply of determining how the impairment affects the given child's functioning.

Evaluation of Effects of Absence of Forearm on Ability to Perform Age-Appropriate Activities-

2. This is the case of a 4-month old baby with congenital absence of the left forearm. No other significant problems are alleged or documented at this time. This impairment does not meet the listings.

The DDS has recommended an allowance with a functional equals to 101.03C. We recognize that as an adult, this claimant would probably be denied, but as a young child, development of age-appropriate activities will be greatly impeded by the absence of one forearm.

Hopefully, with therapy and possibly a prosthesis in the future, she will be able to acquire most of the skills needed for daily function.

We would appreciate comment on the appropriateness of our decision.

Proposed Response from Atlanta--The DDS has recommended an allowance with a functional equivalence to 101.03C in the above case of a 4 month old with congenital absence of her left forearm. No other significant problems were alleged or documented. In justification of their decision, the DDS noted that although the claimant would probably not be allowed as an adult, as a young child, development of age-appropriate activities would be greatly impeded by the absence of one forearm. Hopefully with therapy and a prosthesis, she would acquire most of the skills needed for daily function.

The claimant has a severe impairment, but one which does not meet any of the childhood or adult listings. Because the claimant is an infant, her impairment does not significantly interfere with her current age appropriate activities because these activities are only slightly dependent on the use of her upper extremities. However, as put forth by the DDS, the reduction deformity at the level of the forearm, would reasonably be expected to significantly interfere with many of her early developmental landmarks. Although the DDS suggested a functional equivalence to 101.03C, perhaps a more suitable equivalence is to 1.12 and 1.13 in which the functional use of one upper extremity is not expected to be restored for at least one year due to the fracture of a bone, or a soft tissue injury.

A one year diary of the case should allow DDS to more easily determine the extent to which the impairment interferes with her age appropriate activities which by that time will be more dependent upon use of both upper extremities, and how well she has adapted to the impairment or any prosthetic device. (Atlanta, 6/5/91)

Answer:

The RO has requested us to comment on the proposed allowance in the case of this 4-month-old baby with congenital absence of the left forearm and no other significant problems alleged or documented. As the case record was not forwarded for review, we can only respond in terms of very general policy principles and how they would apply in this case.

We have been presented a case situation of a 4-month-old child with congenital absence of her left forearm and no other problems alleged or documented. Assuming the case has been properly developed and the information provided accurately reflects the documentation in file, an allowance is not appropriate. The impairment is severe but does not meet or medically equal a listing. In the absence of any significant functional problems, the impairment cannot be said to substantially interfere with the child's current age-appropriate activities, such as feeding. Since a child born with the absence of a forearm could reasonably be expected to adapt to the deformity, the deformity, in and of itself, would not reasonably be expected to substantially reduce the child's ability to achieve developmental milestones. Thus, since the evidence apparently shows that there is no interference with development or functioning, a finding of functional equals is inappropriate and the selection of a comparison listing moot. Finally, an allowance on the basis of an individualized functional assessment would be inappropriate in the absence of substantial interference with the performance of age-appropriate activities or the expected achievement of developmental milestones.

Again, the above discussion is based on the assumption that the information provided accurately reflects the facts in the case. In an actual case situation, the adjudicator must always examine each case individually, with the particular facts of a given case guiding the decisionmaking in that case.

Episodic Asthma-Mode of Treatment/Therapy in the Evaluation of Listing-Level Severity

3. [A Regional Medical Advisor (RMA)] requested clarification on some information discussed during the recent [childhood disability] training. The instructor's manual at lesson D 1., A.1.a., 2nd bullet, example, discusses asthma requiring modern inhalant therapy instead of parenteral medication. [The RMA] says by definition inhalant therapy is parenteral. Dorland's 25th edition [says] "not through the alimentary tract." In Listing 3.00 C. "Severe attacks of episodic asthma, as listed in section 3.03B., are defined as prolonged episodes lasting at least several hours, requiring intensive treatment such as intravenous drug administration or inhalation therapy in a hospital or emergency room." We would appreciate any clarification you could provide. (Dallas, 3/28/91)

Answer:

Section 3.00C of the listings specifies that the criterion for determining the level of impairment in respiratory impairments, such as episodic asthma, is the frequency of severe episodes despite prescribed treatment. Regardless of the nature of the mode of therapy, the asthmatic attacks must be severe, i.e., intense, for listing-level severity to be met. In the situation where the listing specifies a particular mode of therapy, as in Listing 103.03A, which specifies parenteral medication, listing-level severity would be medically equaled where the frequency and intensity of the asthmatic attacks fulfill the criteria intended by the listing, and treatment is by modern inhalant therapy rather than by means of parenteral medication. The referenced example in the childhood disability training Instructor's Guide is consistent with this policy.

Dorland's 26th edition defines inhalation therapy as "treatment . . . as by the use of respirators, aerosol-producing devices, and the therapeutic use of oxygen, helium-oxygen, and carbon dioxide mixtures." This same edition defines parenteral, and by implication parenteral treatment/therapy, as "not through the alimentary canal but rather by injection through some other route, as subcutaneous, intramuscular, intraorbital, intracapsular, intraspinal, intrasternal, intravenous, etc." Thus, while inhalation treatment comes under the broad classification of treatment other than "not through the alimentary canal," it does not follow that this type of therapy is parenteral.

Sudden Infant Death Syndrome (SIDS)

4. Could you provide guidelines on documentation and evaluation of Sudden Infant Death Syndrome (SID[S]) babies? (Philadelphia, 3/28/91)

Answer:

Sudden Infant Death syndrome (SIDS) is the unexpected and unexplained death of an apparently well, or virtually well, infant. It is the most common cause of death of infants between ages 2 weeks and 1 year.

Infants at the greatest risk for SIDS appear to be those who have had repeated episodes of cyanosis and apnea, or required CPR. Otherwise, risk factors are not that well understood to be very useful in predicting actual sudden death. Underlying seizure disorders, other neurological abnormalities, metabolic disorders, cardiac or vascular abnormalities, and arrhythmias are known risk factors for SIDS and can be evaluated according to current adjudicative guidelines for the specific impairment(s) involved.

Although many premature infants are discharged home with apnea monitors, the use of a monitor would not, in itself, demonstrate the existence of a medically determinable impairment. In most instances, reevaluation of the infant at about 6 months of age usually shows a continuous 2-month or greater period without apneic episodes and the monitor can be safely discontinued. It is very uncommon for apnea of prematurity, without other underlying organic factors, to persist beyond the age of 12 months.

12/12/91

[1] From: ||childhood hotline at ~CO 12/12/91 2:42PM (1191 bytes: 15 ln)
To: FRED L. CRAWFORD, John Snee at ~S6A, Helene Weintraub, ||ATL ORC at ~~ATLANTA, ||BOS ORC at ~~BOSTON, ||CHI ORC at ~S2D5, ||DAL ORC at ~S2D6, ||DEN ORC at ~~DENVER, ||KC ORC at ~~KC, ||NY ORC at ~~NY, ||OIO DRDD DDB at ?ECB, ||PHI ORC at ~~PHILADELPHIA, ||S3C2, ||SEA ORC at ~~SEATTLE, ||SF ORC at ~~SF, |||S3GP OPPE at ~S3G, ||S3C3, ||S3C
Receipt Requested
Subject: Childhood Disability Hotline Q & A No. 6
---------- Message Contents ----------

This is the sixth installment of the Childhood Disability Hotline Questions and Answers (Q & A). There are six questions organized under six topic headings in this transmittal.

Please provide copies to DPB, ROPIR, and DQB. The DPB should provide copies to each DDS as soon as possible.

Inquiries about these Q & A should be addressed to the RO Zebley coordinators. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf, at FTS 625-9245.

Please see attached Wordperfect file 5.0 named 3137J.W50.

This is the sixth installment of the Childhood Disability Hotline Questions and Answers (Q & A). There are six questions organized under six topic headings in this transmittal.

Inquiries about these Q & A should be addressed to the RO Zebley coordinators. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf, at FTS 625-9245.

Listings 113.03A vs. Listing 13.03A--Child Attains Age 18 Shortly After Filing

1. How should we adjudicate a case where a child age 17 years 10 months meets listing 113.03 A but would be a denial if adjudicated under listing 13.10 A? Case reference: [SANITIZED] and copy of case file provided. (New York, 4/19/91)

   Answer:

   The referenced case is that of a 17 year, 10 month old girl, who filed for benefits on February 12, 1991, alleging disability from December 1990 due to periosteal osteosarcoma of the left tibia. A surgical resection was performed in December 1990. The pathology report showed low grade tumor in most areas with some areas of high grade cells. The case record, which was current at the time of adjudication, showed no additional therapy beyond postoperative care and appropriate physical therapy, and no evidence of metastatic disease or evidence that the cancer had not responded to prescribed therapy.

   The Part B listings are applicable only to the evaluation of impairments of persons under age 18. Therefore, where the date of filing is before age 18, the claim should first be evaluated under the Part B listings. Where a Part B listing is met, and all other factors of eligibility are present, an allowance is appropriate.

   With respect to the instant case, a review of the evidence shows that the claimant has had a satisfactory postoperative course following surgery in December 1990 for a periosteal osteosarcoma of the left tibia. There was no additional therapy other than postoperative care and appropriate physical therapy. The record contains no evidence of metastatic disease or evidence that the cancer has not responded to prescribed therapy. Therefore, on the basis of the evidence in the case record, the DDS and the region are correct in finding that this child meets

Listing 113.03A at age 17 years, 10 months (the time of filing) and should be found disabled even though she would not meet the applicable adult listing had she filed barely two months later at age 18.

However, the fact that the adult listing would not be met does not mean that a claim filed at age 18 would be denied. Rather, additional information as to whether further antineoplastic interventions are planned and over what period, to what degree and for how long the claimant would be limited because of post-therapeutic residuals, whether the claimant will continue to need aid in ambulation and for how long, and the presence of symptoms, such as pain, would be needed before a determination as to disability could be made.

IFA: Special Accommodations and/or Considerations

2. When a child has an increased ability in functioning as a result of special accommodations and/or considerations, how are we to adjudicate these cases? If the special accommodation or consideration is removed, it would be expected that these children would again experience functional limitations. Please provide guidance on how to proceed in these cases? (Dallas, 5/6/91)

Answer:

Interventions for a child's impairment(s) that involve special considerations or accommodations would include highly structured or supportive environments and adaptations, such as assistive devices, appliances, or technology. A child's functioning may be enhanced when he or she lives or goes to school in a highly structured setting. Similarly, a child's functioning may be ennanced by the use of an adaptive device. However, we do not evaluate these two situations in the same way.

When a child lives, or attends school, in a highly structured setting, and his or her functioning improves in that environment, the focus of our evaluation is how tne child would function in normal, age-appropriate settings. We need to consider how the child would function without the supportive structure that is used to control, guide, and alter his or her functioning and behavior. We are less interested in how the structural setting serves to improve the child's functioning then we are in whether, or the extent to which, the child can function independently, appropriately, and effectively in an age-appropriate manner outside that setting.

When a child has a condition that requires the use of any kind of adaptation, and his or her functioning improves with the use of it, the focus of our evaluation is how the adaptation affects the child's functioning. That is, to what degree the adaptation enables the child to function independently, appropriately, and effectively in an age-appropriate manner as compared to unimpaired children. Given the assumption that most adaptations prescribed for children are, indeed, necessary to their functioning, we are not interested (as we are in the case of structured environments) in how the child functions without the adaptation, but how well the child functions with it. Some adaptations can improve a child's functioning to the point that the child can function normally, or almost normally. Others may enable the child to function at a minimal level, but not at all within age-appropriate norms. Still others may impose additional limitations on the child's functioning. The effects of an adaptation depend on many conditions: the nature of the child's impairment, the child's age, how well the child copes with the impairment, the nature of the adaptation, how obtrusive it is, whether it enables as well as, perhaps, complicates a child's functioning, and so forth.

Functional Equals Example 10--Child Under Age 1 at Filing, But Attains Age 1 Prior to Adjudication

3. DI 25215.015B, example 10, provides for a functional equals allowance for a child who weighs less than 1200 grams at birth; these criteria apply until attainment of 1 year of age. Is this age cut-off to be applied mechanically? If a child meets this criteria at the time of filing, but turns age 1 before adjudication, can the criteria still be applied? (New York, 4/10/91)

Answer:

This question parallels a question raised by Kansas City with respect to Example 13 which we responded to in our second transmittal. (See Transmittal No. 2, Question 12, dated May 15, 1991.) Under the new childhood disability rules, a child who satisfies the criteria of functional equivalence in POMS DI 25215.015B, example 10 should be found disabled from birth to at least the attainment of age 1. Thus, if the claim is filed prior to age 1, but adjudicated after age 1, find the child disabled beginning with the date of the application and consider whether the disability ended at any time after the child attained

age 1. A closed period can be established if the child no longer meets or equals a current listing, has demonstrated medical improvement related to the ability to work, (as defined for children), and the child no longer has a disabling impairment. A closed period may also be appropriate where one of the exceptions to medical improvement applies. The ending date could be in any month after the month of attainment of age 1 in which all the criteria for a cessation are met.

In cases of children with birthweights of less than 1200 grams, it is important to keep in mind that children with such low birthweights who survive past their first year often have serious medical problems that persist beyond age 1. Therefore, where the child attains age 1 prior to adjudication of the initial claim or at the time of a scheduled continuing disability review, extreme care must be taken in the evaluation of wnether the child is still disabled despite any medical improvement.

We would also like to correct a technical statement we made in response to Question 12, Transmittal No. 2. In our response we erroneously indicated that a special notice was required in disability closed period cases. Although a notice is required where a continuing disability review results in a proposed termination of benefits based on a finding that disability has ceased, no advance notice is required where the cessation is part of an initial closed period allowance.

Need for Rationale Where Claimant Meets a Functional Equals Example in DI 25215.015B.

4. Has any consideration been given to not requiring a rationale for functional equals if it meets one of the examples given in POMS? . . . . Or at least using a simplified rationale? (Kansas City, 4/5/91)

Answer:

No. Since this is a new policy that we need to monitor carefully, the case record must clearly reflect how the adjudicator reached the conclusion that a child's impairment functionally equals the severity of a listed impairment. As with other childhood cases, an independent reviewer will be looking at the file. In functional equals determinations, this reviewer must be able to tell from the case record exactly what reasoning process led the adjudicator to the determination made. Therefore, it is

necessary to prepare a rationale for cases that fit the functional equivalence examples in POMS DI 25215.015B. To the extent that some of the examples of functional equivalence are quite specific (e.g., the examples of low birthweight), the rationale will not be especially extensive. However, some examples--such as the ones that incorporate specific functional limitations--will require more explanation and may not be "simplified."

Need for Complete Field Office Disability Interview

5. Are there any case situations where it would be appropriate for the FO to curtail the disability interview? Regionally, we feel that the interview should never be curtailed in a child case. However, one of our FOs wanted to curtail the interview in a case involving an infant who was hospitalized and undergoing renal dialysis. If the interview should not be curtailed in child cases, then POMS DI 11005.020 should state this. If a curtailed interview might be appropriate in some situations, could a list be issued of diagnoses, age levels, and other factors which would have to be met in order to use this procedure? (New York, 3/15/91)

Answer:

The RO asked this question in March, prior to the issuance of POMS DI 11005, Transmittal No. 17. As we make clear in that transmittal, a child's functioning must be considered before denying a claim for benefits. As the SSA-3820-F6 (Medical History and Disability Report-Widow, Widower, Surviving Divorced Wife or Disabled Child), provides information about the child's daily activities and school attendance necessary to evaluate the child's functioning, completion of this form should not be curtailed in title XVI disabled child claims. Therefore, a list of factors which would have to be met to curtail an interview would not be appropriate.

POMS DI 25200 Basic Transmittal Action Notes 2-5

6. Reference POMS DI 25200 Basic Transmittal, Action Notes 2-5. Since there are DC cases for children between 18 and 21, shouldn't the reference to SSI children be more appropriately "SSI children under 18"? (Seattle, 4/29/91)

Answer:

Yes. We will incorporate the change in a future POMS transmittal for the DI 252 chapter.

This is the fifth installment of the Childhood Disability Hotline Questions and Answers (Q & A). There are seven questions organized under five topic headings in this transmittal.

Inquiries about these Q & A should be addressed to the RO Zebley coordinators. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf at FTS 625-9245.

Reproduction of Medical Reference Texts-Harriet Lane Handbook

1. Do we have approval to reproduce the Harriet Lane Handbook (Johns Hopkins-Publisher, Peter C. Rowe)? (Kansas City, 4/5/91).

   Answer:

   No, we have not requested permission to reproduce any of the contents of the handbook nor do we have plans to request such permission. We realize that this handbook, which is commonly distributed to interns and residents, is popular with many physicians. It is a compilation of many sources to which the physician might need to refer frequently. The handbook mainly contains tables and algorithms for use by the busy house officer or practitioner and is not intended to be a complete or balanced review or discussion of any single topic. In conjunction with adjudication and review of childhood disability claims, source material in basic pediatric texts, such as those edited by Rudolph or the Nelson text, are the most appropriate source materials, in addition to the relevant journal articles which comprehensively describe a particular medical condition.

Zebley Readjudication Case--Establisning Onset After Age 18

2. If we are developing a Zebley readjudication case and the child is not disabled before attainment of age 18, but the evidence does document an onset after attainment of age 18, should this case be processed as a DC or DI? In this situation, should we set onset as of the first day of disability (i.e., will this applicant be eligible for benefits under Zebley even though disability began after attainment of age 18)? (Atlanta, 3/19/91)

Answer:

The onset date should be shown as the first date of disability. No new application is necessary; the date of filing should be shown as the date of the application reopened under the Zebley readjudication procedures. Even though the allowance action in the circumstances described is technically not under the Zebley rules, the system will not accept DI basis codes for DC cases. For the present, therefore, use the DC basis code that most closely approximates the appropriate DI basis code until further notice. (For a further discussion of basis codes, please see Q & A No. 3, Question Nos. 15 and 16, and Question Nos. 3 and 4 below).

NOTE: Since the childhood disability rules are intended to establish disability based on a standard of comparable severity to the adult standard, it should not be possible to find the same individual with the same impairment(s) and the same functional limitations disabled after age 18, but not earlier. Therefore, we must assume that the child's condition has changed, i.e., there has been a worsening of the impairment(s) present before age 18 or a new impairment which led to the finding of disability at the later onset date. If there has been no change at all in the claimant's impairment(s), the decision as to disability before age 18 should be reexamined. (See Q & A No. 2, Question No. 13.)

Regulations Basis Codes

3. In cases involving emancipated children who are under age 18 (type of case is DI), the child regulations are used for evaluation. Which regulation basis codes are to be used on the SSA-831 and input to the NDDS, the adult codes or the child codes? If child reg basis codes are to be used on the SSA-831, will the NDDS accept these codes for DI cases? If not, is a systems change contemplated to accommodate them? (New York, 4/12/91)

Answer:

The adult regulation codes must be used on the SSA-831 and input to the NDDSS if emancipated children under age 18 are coded as DI cases. At present, edit conditions in the SSI system prevent DC regulations basis codes from being used on DI cases. Future systems changes will take into consideration how we can more accurately code these type of cases.

4. What regulation basis codes (adult or child) should be used for claimants who attain age 18 after filing but before adjudication? If adult basis codes are used, as they have been in the past, what basis code would be used for a functional equals? (Philadelphia, 4/8/91)

Answer:

The childhood disability regulations basis codes should be input in the situation where the child is under age 18 at the time of filing, but attains age 18 before adjudication. Since the SSI system will not accept DI basis codes for DC cases, use the DC basis code that most closely approximates the DI code. (See Q & A No. 3, Question No. 15.) As we noted in response to Q & A No. 2, Question No. 18, since functional equals does not apply to adults, the principle of functional equivalence should not be the basis for a determination if the date of eligibility is at age 18 or later.

Spanish Language Notice

5. We recently received via cc:Mail the Spanish language version of the SSA-L444-U2 (SSA-L444-U3 SP). With reference to page 3 of file Item 2, the last sentence of paragraph 4 indicates that in children under age 18, disability is based solely on a severe physical or mental impairment. This language has been revised in all other childhood notices, since we now address comparable severity in childhood disability claims. Shouldn't this language also be changed in the Spanish notices? (Philadelphia, 4/8/91)

Answer:

Yes. Our teletype IT 23-91 of March 14, 1991, instructed field offices to delete the sentence "Children under age 18 must be found disabled based only on a severe physical or mental condition" from the reverse of the SSA-L444-U2. This instruction applies equally to Spanish language notices.

6. We received a Spanish language version of the SSA-L444-U3 SP via cc:Mail. Spanish decision paragraphs have been provided in file item 3, but the actual personalized decision notice (PDN) is in English. Was this intended? (Philadelphia, 4/8/91)

Answer:

In April we advised the Philadelphia Regional Office by telephone that since the personalized denial notice (PDN) will be in English (see Program Operations Manual System DI 26525.035), we were in error when we provided a Spanish translation of decision paragraphs that are used in the PDN. Although we received no further questions on tnis issue, we have included the question and answer in this transmittal for the record.

Processing Reconsideration Requests--Initial or Reconsideration Denial Under Interim Standard

7. Pending approval to resume processing interim standard cases:

   1. Should FOs take reconsideration applications in interim standard denial cases?
   2. If no, what do we tell the claimant?
   3. If yes, should FOs change the level of claim to initial?
   4. Should the FO send tne case to the DDS? If yes, should the DDS log the case as initial or reconsideration?
   5. If the FO should not send the case to DDS, but does so anyway, should the DDS return the case to the FO?
   6. Can favorable recon reversals currently pending in DDS be processed?

   (Philadelphia, 3/28/91)

   Answer:

   The RO asked this question in March 1991, prior to transmission of teletype IT-27-91 dated April 5, 1991. Claims with an unfavorable initial or reconsideration decision under the interim standard are classified as pipeline cases. Teletype IT-27-91 instructed FOs to implement Transmittal No. 18, POMS DI E12597 and Transmittal No. 21, POMS DI E32597. These POMS transmittals replaced the respective FO and DDS interim standard instructions and provided processing instructions, based on the new childhood disability rules, for title XVI childhood disability pipeline claims. Since April we have been processing reconsideration requests in interim standard denials.

TIM FYI - transmitted 10/8/91 - Q+A #4

Questions about these Questions and Answers should be addressed to the RO Zebley coordinator. Any questions that cannot be readily resolved in the RO may be called in to Victoria Dorf, at FTS 625-9245.

Examples of Disabling Impairments

1. POMS DI 25220.025C gives examples of when we will generally find comparable severity and make a determination of disability. Is it possible for an impairment which is less restrictive (e.g., moderate limitation in only 2 domains) to be of comparable severity to that which would disable an adult? (New York, 3/26/91)

Answer:

Yes, but we wouldn't call such an impairment "less restrictive." As you point out, POMS DI 25220.025C only provides illustrations of when we will generally find comparable severity. The POMS instruction flows from Regulation 416.924e(a). That rule explains that the regulatory guidelines "illustrate a level of impairment severity that is generally, though not invariably, sufficient to establish comparable severity . . . ." Thus, other descriptors, as in your example, may well describe disabling impairments as long as they meet the level of comparable severity intended by the law; i.e., as long as the extent of the child's functional limitations is of the same severity as that of the illustrations.

In discussing how we describe functional limitations, Regulation 416.924e(b) explains that the terms used to describe functional severity of both physical and mental impairments use as a frame of reference the terminology and definitions in section 112.00 of the childhood mental listings. Thus, the definition and examples of "moderate" limitations are derived from a comparison with the "marked" levels of functional limitations in the listings. Furthermore, just as the term "severe" connotes a range of limitations from just above slight or minimal (i.e., more than "not severe") all the way to "extreme," the term "moderate" connotes a range of limitations from just above slight or minimal up to "marked," and the term "marked" describes limitations that may be very nearly "moderate" at the lower end to very nearly "extreme" at the upper end. Thus, a combination of limitations in two domains that are characterized as moderate but are at the upper end of the range (i.e., nearly marked) could support a finding of disability at the last step of the sequence. Similarly, a marked limitation in one domain which approximates an

extreme (or listing-level) limitation of functioning may constitute a disabling level of impairment on the basis of that one area alone.

Finally, a cautionary note. The determination of disability must always be based on the specific factors in the individual child's case. Thus, we reiterate that the guidelines for evaluating severity on the basis of an individualized functional assessment are presented in terms of illustrative examples of disabling configurations of impairment. As we explained in the training, three moderate limitations in which all the limitations are just above the slight or minimal level, or a configuration of one marked limitation bordering on moderate in combination with a moderate limitation bordering on "slight," need not always be disabling. The example assumes three good, solid moderates. On the other hand, as shown above, we cannot presume that a child with a marked limitation of functioning in only one domain (or moderate limitations in two domains) is not disabled. Again, this underscores the need for case-by-case adjudication based on the specific factors in the individual child's case.

Multiple IFAs

2. If a child's age changes after filing but before adjudication and the new age would require a different IFA form per DI 25220.100 (e.g., changes from age 15 to 16) would it be necessary to prepare two IFA forms, one for each age level? (New York, 4/16/91)

When a child changes age before DDS adjudication, there may be different factors that are pertinent to an IFA if the child changes to a new age category (e.g., age 1, age 3, age 6, age 16). For example, concentration/persistence/pace are IFA factors at age 3 but not before that age; work-related functions are a factor at age 16 but not before that age. DI 25205.010 does not provide any guidance to the DDS in documenting function when the child is approaching a borderline age level during case processing. Could some discussion be provided for the DDSs on how to handle these case situations? (New York, 5/9/91)

Answer:

When a child's age category changes after filing but before adjudication, so that two age categories are involved, prepare an IFA for the child using the applicable domains and behaviors under the younger age category. If

disability cannot be established on the basis of that IFA, do an IFA using the applicable domains and behaviors of the older age category to determine if the child is disabled. If disability can be established only on the basis of the IFA for the older age category, establish onset as of the first date the IFA shows disability. In the last instance, however, be sure that there is no unresolved inconsistency between your IFAs at the different age levels. There should be no inherent advantage to assessing disability in a later age category. If a child is disabled based on your IFA in the older age category but not in the younger age category, the only justification should be that the child's impairment(s) had gotten worse (or that there were additional impairments that arose later); otherwise, you should either have found the child disabled at the earlier age, or not disabled at the later age. In any event, you must explain why you found the child not disabled at the earlier age and then subsequently under a disability. (It is also possible to find that the child was disabled at the younger age, but is no longer disabled at the older age, leading to a finding of a closed period of disability.)

Childhood Listings-Child Attains Age 18 After Filing but Prior to Adjudication

3. For the claimant who files before age 18 but turns age 18 prior to adjudication, how do we evaluate the claimant meeting a childhood listing such as Down syndrome or hearing impairment with 70 decibel hearing loss? These instructions have either no comparable adult listing or have stricter adult listing requirements. Should we allow these claims since they have filed as children and adjudicate them as open period allowances (assuming no medical improvement)? How about closed period allowances under age 18? (New York, 4/18/91)

Answer:

The childhood listings are applicable in situations in which a child files before age 18, even if the child turns age 18 prior to adjudication. Thus, in both examples presented by the regional office (RO), the claim should be adjudicated using the childhood sequential evaluation process with consideration given first to the Part B listings at Step 3 in that process.

As the RO points out, there are instances in which Part B includes impairments or sets of criteria that differ from the impairments and/or criteria in the adult standard. The RO has presented two examples in which this occurs, Down syndrome and hearing impairment.

In both examples, a child whose impairment meets one of the childhood listings cited--Listing 110.06 (non-mosaic Down syndrome), Listing 110.07 (Multiple body dysfunction (including mosaic Down syndrome)) and Listing 102.08B (Hearing impairments)--would generally be found entitled to an open period of disability and the claim would be diaried for a continuing disability review under the rules in Program Operations Manual System (POMS) DI 25225.005B. This policy is consistent with our longstanding policy and was not changed by the new childhood disability rules. (A closed period could be possible in cases in which the adjudication is a year or more after onset and the claimant's impairment had improved.) As a further note, POMS DI 28015.200 includes hearing impairment in the examples of the application of listing criteria when criteria differ by age.

For questions regarding the choice of age category in the preparation of the IFA when a claim covers more than one category see Q & A No. 2, Question 13, and Q & A No. 3, Question 10.