



4191-02U

SOCIAL SECURITY ADMINISTRATION

20 CFR Parts 404 and 416

[Docket No. SSA-2006-0112]

RIN 0960-AG38

Revised Medical Criteria for Evaluating Musculoskeletal Disorders

AGENCY: Social Security Administration.

ACTION: Notice of proposed rulemaking.

SUMMARY: We propose to revise the criteria in the Listing of Impairments (listings) that we use to evaluate claims involving musculoskeletal disorders in adults and children under titles II and XVI of the Social Security Act (Act). These proposed revisions reflect our adjudicative experience, advances in medical knowledge and treatment of musculoskeletal disorders, and recommendations from medical experts.

DATES: To ensure that your comments are considered, we must receive them no later than **[INSERT DATE 60 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**.

ADDRESSES: You may submit comments by one of three methods – Internet, fax, or mail. Do not submit the same comments multiple times or by more than one method. Regardless of which method you choose, please state that your comments refer to Docket No. SSA-2006-0112 so that we may associate your comments with the correct regulation.

CAUTION: You should be careful to include in your comments only information that you wish to make publicly available. We strongly urge you not to include in your comments any personal information, such as Social Security numbers or medical information.

1. Internet: We strongly recommend that you submit your comments via the Internet. Please visit the Federal eRulemaking portal at <http://www.regulations.gov>. Use the Search function to find docket number SSA-2006-0112. The system will issue you a tracking number to confirm your submission. You will not be able to view your comment immediately because we must post each comment manually. It may take up to a week for your comment to be viewable.

2. Fax: Fax comments to (410) 966-2830.

3. Mail: Address your comments to the Office of Regulations and Reports Clearance, Social Security Administration, 107 Altmeyer Building, 6401 Security Boulevard, Baltimore, Maryland 21235-6401.

Comments are available for public viewing on the Federal eRulemaking portal at <http://www.regulations.gov> or in person, during regular business hours, by arranging with the contact person identified below.

FOR FURTHER INFORMATION CONTACT: Cheryl A. Williams, Office of Disability Policy, Social Security Administration, 6401 Security Boulevard, Baltimore, Maryland 21235-6401, (410) 965-1020. For information on eligibility or filing for benefits, call our national toll-free number, 1-800-772-1213, or TTY 1-800-325-0778, or visit our Internet site, Social Security Online, at <http://www.socialsecurity.gov>.

SUPPLEMENTARY INFORMATION:

This notice of proposed rulemaking (NPRM) is divided into several parts. First, we provide the supplementary information, which is often referred to as the preamble. In the preamble, we explain why we propose to revise the listings for the musculoskeletal body system and how we developed the proposed rules. We also offer a narrative of the changes we are proposing. The preamble tells the story behind the proposed rule changes, but if we decide to proceed with a final rule, the preamble will not become part of the Code of Federal Regulations.

The next section is the proposed revisions to the listing of impairments, located in Appendix 1 to Subpart P of 20 CFR Part 404. For each body system affected by these proposed rules (e.g., 1.00 Musculoskeletal Disorders), we first provide proposed changes to the introductory text (e.g., 1.00A, B, C, etc.). If we decide to proceed with a final rule, the introductory text will become part of the Code of Federal Regulations. The introductory text details which disorders we evaluate and what evidence we need to

conduct this evaluation. It also defines certain terms, and provides valuable background information. Individuals often refer to the introductory text for additional details related to a specific listing under which a medically determinable impairment (MDI) is being evaluated. After the introductory text, we provide specific listing text and criteria (e.g., 1.15 and 1.16). The listings themselves provide specific criteria that an MDI must meet (or medically equal) in order for an individual to be found disabled under the listings.

I. Why are we proposing to revise the listings for the musculoskeletal body system?

We last published final rules that revised the musculoskeletal body system on November 19, 2001.¹ We are now proposing to update the introductory text and criteria in the current listings to reflect our adjudicative experience, advances in medical knowledge and treatment of musculoskeletal disorders, and comments and recommendations from medical experts.

While we believe our proposed revisions reflect advances in medical knowledge and treatment of musculoskeletal disorders, we are interested in receiving public comments on the following issues:

- Are there any musculoskeletal disorders that will meet one of the proposed listings, but are generally expected to medically improve after a certain amount of time to the point at which the disorders will no longer be of listing-level severity? If you believe

¹ 66 FR 58010. We also made a conforming change to the rules for musculoskeletal disorders when we published final rules revising the rules for immune system disorders on March 18, 2006 (73 FR 14570).

there are musculoskeletal disorders that fit into this category, please tell us by submitting your comments and any supporting research or data. We will use your comments on this issue to inform our policy on the timing of continuing disability reviews.²

- Are the proposed functional criteria appropriate and sufficient for assessing listing level severity? If you believe the proposed functional criteria are either insufficient for documenting an impairment that meets a listing-level severity, or you believe these criteria will exclude eligible individuals with an impairment of listing-level severity, please tell us by submitting your comments and any supporting research or data.

- Did we remove or omit any valuable information that should be included in the introductory text? We intend for this text to ease administrative burdens for adjudicators, claimants, claimant representatives, and the public by clarifying terms, removing extraneous language, and providing guidance in an orderly fashion. If you believe we removed or omitted any valuable information, please tell us by submitting your comments and any supporting research or data.

- Should any of the proposed listings for musculoskeletal disorders be combined into one listing or divided into multiple listings for adjudicative ease and capture individuals with impairments that meet a listing-level severity? If you believe our listing categories create unnecessary administrative barriers for impairments that meet listing level severity, please tell us by submitting your comments and any supporting

² See §§ 404.1590 and 416.990 of this chapter for our policy on when we will conduct a continuing disability review.

research or data.

- Did we appropriately define “close proximity of time” in section 1.00C7 as meaning that all of the relevant criteria have to appear in the medical record within a period not to exceed 4 months of one another for musculoskeletal disorders? The 4-month threshold represents a period in which an individual receiving treatment for a chronic severe musculoskeletal impairment will undergo multiple examinations or treatments from their medical source(s). Individuals with chronic severe musculoskeletal impairments typically undergo multiple examinations or treatments. Therefore, we believe a 4-month threshold provides individuals with adequate time to receive multiple medical treatments documenting the existence of listing level criteria, should the relevant criteria exist. If you believe the “close proximity of time” should be defined by a different measure than 4 months, please tell us by submitting your comments and any supporting research or data.

- Based on advances in medical surgical, recuperative, and functionally restorative treatment of musculoskeletal disorders, would the proposed listing criteria allow us to adequately assess whether an individual has achieved “maximum benefit from therapy” or whether an individual is “under continuing surgical management”? It is important that we do not encourage or incentivize individuals to increase their medical treatment to maintain or access disability benefits, particularly medical treatments that would likely be ineffective, or that may even be harmful, for the individual? If you believe “the maximum therapeutic benefits” criterion should be revised and evaluated by

a different measure, please tell us by submitting your comments and any supporting research or data.

II. How did we develop these proposed rules?

As medicine and medical treatment are continuously evolving, we utilized well-known references such as the Guides to the Evaluation of Permanent Impairment from the American Medical Association, Harrison's Principles of Internal Medicine, Current Diagnosis & Treatment in Orthopedics, and Nelson Textbook of Pediatrics as a starting point to develop the proposed changes to these rules.³ We also requested extensive input from our medical consultants (physicians employed by or who contract with us) who have years of experience practicing in relevant fields of medicine and who have intimate knowledge of our disability programs to develop our proposed changes to the musculoskeletal disorders listings. We rely on our medical consultants and their professional opinions based on their clinical experience and research to help us develop what criteria correspond with listing-level severity.

In developing our proposed rule changes, we used the resources above, our programmatic knowledge, our adjudicative experience, and the medical literature, such as Archives of Physical Medicine and Rehabilitation, Journal of the American Academy of Orthopaedic Surgeons, and Hand Clinics. These resources informed us of the most recent best practices and medical advancements and either support, or are consistent with, our

³ Full citations are available in X. References below.

proposed rule changes.

In addition to these distinguished medical sources and our medical consultants, in proposing these changes to the musculoskeletal disorders listings, we used information from:

- People who make and review disability determinations and decisions for us in State agencies, in our Office of Quality Review, and in our Office of Hearing Operations;
- Comments we received regarding the 2001 “Final rules with request for comment,”⁴ which we used as a starting point for identifying areas needing further research; and
- Additional published sources we list in the References section at the end of this preamble, including the National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division (formerly the Institute of Medicine).

III. What major revisions are we proposing?

We propose to revise both the content and the structure of the adult and childhood musculoskeletal disorders listings and introductory texts as follows:

⁴ The final rules with request for comments are available at <http://www.gpo.gov/fdsys/pkg/FR-2001-11-19/pdf/01-28456.pdf>. Comments on the final rules may be found at <http://www.regulations.gov/>, and search for “SSA-2006-0112”.

- Provide uniform and specific severity criteria for evaluating the effects of a musculoskeletal disorder on a person's functioning;
- Revise the introductory texts in 1.00 Musculoskeletal Disorders and 101.00 Musculoskeletal Disorders to provide guidance on the specific severity criteria;
- Add specific sections in the introductory texts in 1.00 Musculoskeletal Disorders and 101.00 Musculoskeletal Disorders to provide guidance on each listing;
- Revise the content and structure of the current listings to incorporate the new severity criteria into each listing;
- Add listings for evaluating pathologic fractures due to any cause (1.19 Pathologic fractures due to any cause for adults and 101.19 Pathologic fractures due to any cause for children);
- Add a child listing for evaluating musculoskeletal disorders of infants and toddlers, from birth to attainment of age 3, with developmental motor delay (101.24 Musculoskeletal disorders of infants and toddlers, from birth to attainment of age 3, with developmental motor delay);
- Use the same general structure in most adult and child listings, consisting of

symptoms, signs, laboratory findings, and applicable functional criteria, in that order;

- Remove current 1.02 and 101.02 Major dysfunction of a joint(s) (due to any cause) and incorporate the provisions in proposed 1.18 and 101.18 Abnormality of a major joint(s) in any extremity;

- Remove current 1.04 Disorders of the spine and 1.04A “Evidence of nerve root compression,” and incorporate the provisions of 1.04A in proposed 1.15 Disorders of the skeletal spine resulting in compromise of a nerve root(s);

- Remove current 1.04B “Spinal arachnoiditis” because it is a secondary effect, rather than a primary skeletal spine disorder, which can be evaluated under proposed 1.16 Lumbar spinal stenosis resulting in compromise of the cauda equina;

- Remove current 1.04C “Lumbar spinal stenosis,” and incorporate its provisions in proposed 1.16 Lumbar spinal stenosis resulting in compromise of the cauda equina;

- Remove current 101.04 Disorders of the spine and incorporate the provisions in proposed 101.15 Disorders of the skeletal spine resulting in compromise of a nerve root(s) and 101.16 Lumbar spinal stenosis resulting in compromise of the cauda equina;

- Remove current 1.05 and 101.05 Amputation (due to any cause), and

incorporate its provisions in proposed 1.20 and 101.20 Amputation due to any cause;

- Remove current 1.06 and 101.06 Fracture of the femur, tibia, pelvis, or one or more of the tarsal bones; and incorporate the provisions of those listings in proposed 1.22 and 101.22 Non-healing or complex fracture of the femur, tibia, pelvis, or one or more of the tarsal bones;

- Remove current 1.07 and 101.07 Fracture of an upper extremity; and incorporate the provisions of those listings in proposed 1.23 and 101.23 Non-healing or complex fracture of an upper extremity; and

- Remove current 1.08 and 101.08 Soft tissue injury (e.g., burns), and incorporate the provisions in proposed 1.21 and 101.21 Soft tissue injury or abnormality under continuing surgical management.

IV. What changes are we proposing to the introductory text of the musculoskeletal disorders listings for adults?

We propose to adopt a question-and-answer framework to make the guidance contained in the introduction easier for adjudicators, claimants, claimant representatives, and the public to locate, and to make the introductory text consistent with the format used in other body systems.

We propose to remove the phrases “loss of function” and “functional loss” and replace the content of current 1.00B1 General, 101.00B1 General, 1.00B2 How we define loss of function in these listings, and 101.00B2 How We Define Loss of Function in These Listings. We are replacing the content of 1.00B1 General and 101.00B1 General because it may be read to imply that we require an absence of function in order to evaluate an impairment under these listings. Except in the case of amputation, the proposed listings do not require a complete absence of function. In 1.00B2 How We Define Loss of Function in These Listings and 101.00B2 How We Define Loss of Function in These Listings, we are removing the descriptive phrases, “inability to ambulate effectively,” “extreme limitation of the ability to walk,” “interferes very seriously with the individual’s ability to independently initiate, sustain, or complete activities,” “ineffective ambulation,” and “independent ambulation,” along with the corresponding examples in that paragraph. We are replacing these descriptors with uniform and specific severity criteria, which we believe will provide clearer guidance for adjudicators and the public.

We propose to provide new uniform and specific functional criteria, which we describe in the introductory text for each listing, for evaluating the severity of limitations caused by musculoskeletal disorders. We chose these particular functional criteria because they clearly illustrate the level of dysfunction for upper and lower extremities that would cause an adult to be unable to work, or that would cause a child to be unable to perform age-appropriate activities. The effects of a particular disorder on musculoskeletal functioning, and the treatment needed, direct which of these criteria are

appropriate for each of the listings. The functional criteria for adults are as follows:

1. A documented medical need for a walker, bilateral canes, or bilateral crutches;
2. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements, and a documented medical need for a one-handed assistive device that requires the use of the other upper extremity; or
3. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements.

In developing this uniform and specific severity criteria, we utilized medical resources, such as “Ambulatory Assistive Devices in Orthopaedics: Uses and Modifications,”⁵ the professional experience of our medical consultants, information related to workplace functioning from the Bureau of Labor Statistics, and our adjudicative experience. Each of these criteria illustrate restrictions of multiple extremities and thus, significant limitations.

We propose to explain each proposed listing in separate sections of the introduction.

⁵ Full citation is available in X. [References](#), below.

The following chart shows the headings of the current and proposed sections of the adult introductory text:

Current Introductory Text	Proposed Introductory Text
A. <u>Disorders of the musculoskeletal system</u>	A. <u>Which disorders do we evaluate under these listings?</u>
B. <u>Loss of function</u>	B. <u>Which related disorders do we evaluate under other listings?</u>
C. <u>Diagnosis and Evaluation</u>	C. <u>What evidence do we need to evaluate your musculoskeletal disorder under these listings?</u>
D. <u>The physical examination</u>	D. <u>How do we consider symptoms, including pain, under these listings?</u>
E. <u>Examination of the Spine</u>	E. <u>How do we use the functional criteria under these listings?</u>
F. <u>Major joints</u>	F. <u>What do we consider when we evaluate disorders of the skeletal spine resulting in compromise of a nerve root(s) (1.15)?</u>
G. <u>Measurements of joint motion</u>	G. <u>What do we consider when we evaluate lumbar spinal stenosis resulting in compromise of the cauda equina (1.16)?</u>
H. <u>Documentation</u>	H. <u>What do we consider when we evaluate reconstructive surgery or surgical arthrodesis of a major weight-bearing joint (1.17)?</u>
I. <u>Effects of Treatment</u>	I. <u>What do we consider when we evaluate abnormality of a major joint(s) in any extremity (1.18)?</u>
J. <u>Orthotic, Prosthetic, or Assistive Devices</u>	J. <u>What do we consider when we evaluate pathologic fractures due to any cause (1.19)?</u>
K. <u>Disorders of the spine</u>	K. <u>What do we consider when we evaluate amputation due to any cause (1.20)?</u>
L. <u>Abnormal curvatures of the spine</u>	L. <u>What do we consider when we evaluate soft tissue injury or abnormality under continuing surgical management (1.21)?</u>
M. <u>Under continuing surgical management</u>	M. <u>What do we consider when we evaluate non-healing or complex fractures of the femur, tibia, pelvis, or one or more of the tarsal bones (1.22)?</u>
N. <u>After maximum benefit from therapy</u>	N. <u>What do we consider when we evaluate</u>

<u>has been achieved</u>	<u>non-healing or complex fractures of an upper extremity (1.23)?</u>
O. <u>Major function of the face and head</u>	O. <u>How do we determine when your soft tissue injury or abnormality, or your upper extremity fracture, is no longer under continuing surgical management or you have received maximum therapeutic benefit?</u>
P. <u>When surgical procedures have been performed</u>	P. <u>How do we evaluate the severity and duration of your established musculoskeletal disorder when there is no record of ongoing treatment?</u>
Q. <u>Effects of obesity</u>	Q. <u>How do we evaluate substance use disorders that co-exist with musculoskeletal disorders?</u>
	R. <u>How do we evaluate disorders that do not meet one of the musculoskeletal listings?</u>

Proposed 1.00 – Introduction

The following is a detailed description of the changes we propose to the introductory text.

Proposed 1.00A – Which disorders do we evaluate under these listings?

We propose to revise current 1.00A Disorders of the musculoskeletal system to explain that we evaluate musculoskeletal disorders that result in dysfunction of the

skeletal spine or of the upper or lower extremities,⁶ fractures, and soft tissue⁷ abnormalities or injuries that are under continuing surgical management.

We begin with listings for disorders affecting functioning of the skeletal spine, because our adjudicative experience shows that these are the most frequently used listings in this body system.

Proposed 1.00B – Which related disorders do we evaluate under other listings?

We propose to replace the content of current 1.00B Loss of function with improved guidance for disorders that affect musculoskeletal functioning, which we evaluate under other listings. We explain that we evaluate injuries of the skeletal spine resulting in dysfunction of the spinal cord under 11.00 Neurological Disorders, and we evaluate inflammatory arthritis under 14.00 Immune System Disorders. We state that we evaluate abnormal curvatures of the spine that adversely affect functioning in other body systems under the appropriate listing in the affected body system. We have removed the guidance from current 1.00L that states “Abnormal curvatures of the spine (specifically, scoliosis, kyphosis and kyphoscoliosis) can result in impaired ambulation, but may also adversely affect functioning in body systems other than the musculoskeletal system.”

Instead, we propose to evaluate spinal curvatures that affect musculoskeletal functioning

⁶ Impairments involving the shoulders will typically affect upper extremities while the impairments involving the pelvis, hips, and ribs typically affect lower extremities. When assessing dysfunction, the resultant incapacity or limitation is key to assessing the impairment under the applicable medical listing.

⁷ Soft tissue refers to non-skeletal tissues that make up a large percentage of the body, such as the tendons, ligaments, fascia and muscles.

under proposed 1.15 Disorders of the skeletal spine resulting in compromise of a nerve root(s), depending on the area of dysfunction created by the curvature. We also state that we can evaluate a curvature of the spine that is under continuing surgical management under proposed 1.21 Soft tissue injury or abnormality under continuing surgical management.

Proposed 1.00C – What evidence do we need to evaluate your musculoskeletal disorder under these listings?

We propose to replace current 1.00C Diagnosis and Evaluation with a comprehensive explanation of the information and evidence we need to evaluate musculoskeletal disorders. Once we establish the disorder, we evaluate evidence from medical and non-medical sources to assess severity and duration under the musculoskeletal listings. We describe the elements needed in a physical examination report. We discuss laboratory and other test findings and their usefulness and limitations, and we explain our policy concerning evaluation of imaging and other diagnostic tests. We discuss our need for operative reports and what we will accept in the absence of such reports, incorporating the guidance from current introductory section 1.00P When surgical procedures have been performed. We identify the evidence we need concerning a person's treatment and response to it.

In section 1.00C6 Assistive devices, we clarify what we mean by a prosthesis(es) and an orthosis(es). We discuss the evidence we need when a person with a

musculoskeletal disorder uses an assistive device(s), including a cane(s), crutch(es), walker, prosthesis(es), or orthosis(es).

In section 1.00C7 Longitudinal evidence, we explain the importance of a longitudinal medical record in determining whether a musculoskeletal disorder satisfies the duration requirement. We explain that, for all listings except 1.19 Pathologic fractures due to any cause, 1.20A “Amputation of both upper extremities”, 1.20B “Hemipelvectomy or hip disarticulation”, and 1.21 Soft tissue injury or abnormality under continuing surgical management, all listing criteria must be present simultaneously, or within a close proximity of time; and must have lasted, or be expected to last, for a continuous period of at least 12 months for a disorder to meet a listing.

In section 1.00C What evidence do we need to evaluate your musculoskeletal disorder under these listings?, we clarify that, when the listing criteria are linked by the word “and” (whether in small case or capital case), the requirements must be simultaneously present, or present within a “close proximity of time,” which we define in section 1.00C7 as meaning that all of the relevant criteria have to appear in the medical record within a period not to exceed 4 months of one another. Consistent with the standard of care and common industry practice, according to our medical consultants, literature review, and external medical experts, such as those from the Health and Medicine Division at the National Academies of Science Engineering and Medicine, an individual receiving treatment for a chronic severe musculoskeletal impairment will typically receive treatment or undergo examination at least once every 3 months. Should

an individual meet an applicable listing, the listing criteria is likely to be documented every third month. The 4-month threshold provides leeway in cases where a physical examination might not be performed or symptoms are not documented at a given appointment. The 4-month threshold represents a period in which individuals receiving treatment for a chronic severe musculoskeletal impairment will undergo multiple examinations or treatments from their medical source(s), providing a window encompassing multiple medical appointments over which applicable listing criteria can be adequately documented. The 4-month threshold does not apply to imaging..

We propose to add this clarification to address a holding in Radford v. Colvin, 734 F.3d 288 (4th Cir. 2013) with respect to current 1.04A Disorders of the spine, “Evidence of nerve root compression.” The Radford Court held that “[a] claimant need not show that each symptom was present at precisely the same time—i.e., simultaneously—in order to establish the chronic nature of his condition. Nor need a claimant show that the symptoms were present in the claimant in particularly close proximity.”⁸

Because this holding of the Radford Court differed from our interpretation of the listing requirement, we issued Acquiescence Ruling (AR) 15-1(4) to implement the Court of Appeals holding within the States in the Fourth Circuit.⁹ We now propose to clarify our longstanding interpretation of the regulations in response to the Radford decision. We

⁸ 734 F.3d at 294.

⁹ 80 FR 57418 (2015). Available at: https://www.ssa.gov/OP_Home/rulings/ar/04/AR2015-01-ar-04.html.

also propose to clarify that this policy applies to other listings that have similar requirements.

The issuance of a new regulation to address a holding of a Court of Appeals that conflicts with our policy is consistent with the process described in our regulations for issuing and rescinding Acquiescence Rulings. Our regulations specifically contemplate that we may “subsequently publish a new regulation(s) addressing an issue(s) not previously included in our regulations when that issue(s) was the subject of a circuit court holding that conflicted with our interpretation of the Social Security Act or regulations and that holding was not compelled by the statute or Constitution.” 20 CFR §§ 404.985(e)(4), 416.1485(e)(4). After we have considered the public comments in response to these proposed rules and issued any final rules, we will decide whether we need to rescind the Radford AR.

Section 1.00C8 Surgical treatment, discusses how we evaluate surgical treatment. We explain when and why we may wait to receive additional evidence before making a determination of disability.

Proposed 1.00D – How do we consider symptoms, including pain, under these listings?

We propose to replace current 1.00D The physical examination with guidance about how we consider symptoms of musculoskeletal impairments, particularly pain. We explain that your pain must be supported by medical signs and laboratory findings,

established by medically acceptable clinical, laboratory, or diagnostic techniques, showing the existence of a medical impairment(s) which results from anatomical, physiological, or psychological abnormalities.

Proposed 1.00E – How do we use the functional criteria under these listings?

We propose to replace current 1.00E Examination of the Spine with new guidance about how we use the functional criteria to evaluate musculoskeletal disorders under these listings. We explain what we mean by functional criteria, we list the criteria, and we explain why listings 1.20A ‘Amputation of both upper extremities’, 1.20B “Hemipelvectomy or hip disarticulation” and 1.21 Soft tissue injury or abnormality under continuing surgical management do not include the functional criteria. We also explain that we will evaluate a person’s functioning with respect to the work environment, rather than the home environment, because the ability to walk independently about one's home without the use of assistive devices does not, in and of itself, indicate an ability to walk without an assistive device in a work environment. We explain that in order to be disabling, a musculoskeletal disorder must satisfy the medical criteria as well as the 12-month duration requirement and, where applicable, must include at least one of the functional criteria of a listing.

Proposed 1.00F – What do we consider when we evaluate disorders of the skeletal spine resulting in compromise of a nerve root(s) (1.15)?

We propose to replace the content of current 1.00F Major joints with guidance regarding how we evaluate disorders of the skeletal spine under proposed 1.15 Disorders of the skeletal spine resulting in compromise of a nerve root(s). In proposed 1.00F, we list the various spinal disorders that result in compromise of nerve roots; we explain the symptoms and signs associated with those disorders; and we explain how a medical source evaluates those symptoms and signs in clinical examinations.

Proposed 1.00G – What do we consider when we evaluate lumbar spinal stenosis resulting in compromise of the cauda equina (1.16)?

We propose to replace the content of current 1.00G Measurements of joint motion with guidance about how we evaluate the effects of compromise of the cauda equina due to lumbar spinal stenosis under proposed 1.16 Lumbar spinal stenosis resulting in compromise of the cauda equina. We explain how lumbar spinal stenosis can compromise the cauda equina; we provide a more detailed discussion of the cauda equina and associated symptoms and signs; and we explain how the disorder affects functioning. We also explain the difference between pain caused by compromise of the cauda equina (neurogenic claudication or pseudoclaudication) and pain caused by peripheral arterial disease (vascular claudication).

Proposed 1.00I – What do we consider when we evaluate abnormality of a major joint(s) in any extremity (1.18)?

We propose to replace the content of current 1.00I Effects of Treatment with guidance about how we evaluate abnormality in a major joint(s) under proposed 1.18 Abnormality of a major joint(s) in any extremity. We explain how we define abnormalities of the joints, and give specific examples of the types of diseases, injuries, and other conditions that may contribute to joint dysfunction. We also explain how these disorders interfere with functions of the extremities.

Proposed 1.00J – What do we consider when we evaluate pathologic fractures due to any cause (1.19)?

We propose to replace the content of current 1.00J Orthotic, Prosthetic, or Assistive Devices with guidance regarding how we evaluate pathologic fractures under proposed new 1.19 Pathologic fractures due to any cause. We explain what we mean by “pathologic fractures;” we state that these types of fractures can affect the skeletal spine, extremities, or other parts of the skeletal system; we give examples of disorders that can cause pathologic fractures; and we explain how we evaluate their occurrence and recurrence.

Proposed 1.00K – What do we consider when we evaluate amputation due to any cause (1.20)?

We propose to replace the content of current 1.00K Disorders of the spine with guidance about how we evaluate amputation due to any cause under proposed 1.20

Amputation due to any cause. We explain that we evaluate amputations involving upper or lower extremities and combinations of those extremities, as well as hemipelvectomies and hip disarticulations. We explain that when a person has amputations of one upper extremity at any level above the wrist and one lower extremity at or above the ankle, we consider whether the person has a documented medical need for a one-handed assistive device. We also explain how we consider amputation of one or both lower extremities at or above the ankle (tarsal joint). We state that we use this listing when a person has residual limb complications that have lasted, or are expected to last, for at least 12 months, and the person is not currently undergoing surgical management.

Proposed 1.00L – What do we consider when we evaluate soft tissue injury or abnormality under continuing surgical management (1.21)?

We propose to replace the content of current 1.00L Abnormal curvatures of the spine with guidance about how we evaluate soft tissue abnormality or injury of any part of the body that is under continuing surgical management. We also incorporate the provisions of current sections 1.00M Under continuing surgical management, 1.00N After maximum benefit from therapy has been achieved, 1.00O Major function of the face and head, and 1.00P When surgical procedures have been performed. We explain that we use proposed 1.21 Soft tissue injury or abnormality under continuing surgical management to evaluate any soft tissue abnormality or injury, whether congenital or acquired, including malformations, third- and fourth-degree burns, craniofacial injuries, avulsive injuries, amputations with complications of the residual limb(s), and

complications of non-healing or complex traumatic fractures. We explain that a person must have a documented medical need for a continuing series of ongoing surgical procedures and associated medical treatments, directed toward saving, reconstructing, or replacing the affected part of the body. We further explain that these treatments must have been, or must be expected to be, ongoing for a continuous period of least 12 months. We list the clinical evidence we need to determine whether a disorder meets this listing. We explain how we evaluate third- and fourth-degree burns and craniofacial injuries. We also explain how we evaluate when maximum therapeutic benefit has occurred and how we evaluate residual impairment.

Proposed 1.00M – What do we consider when we evaluate non-healing or complex fractures of the femur, tibia, pelvis, or one or more of the tarsal bones (1.22)?

We propose to replace the content of current 1.00M Under continuing surgical management with guidance about how we evaluate non-healing or complex fractures involving bones in the lower extremity. We also provide definitions for “non-healing fracture” and “complex fracture.”

Proposed 1.00N – What do we consider when we evaluate non-healing or complex fractures of an upper extremity (1.23)?

We propose to replace the content of current 1.00N After maximum benefit from therapy with guidance about how we evaluate non-healing or complex fractures involving bone in

the upper extremity. We also provide definitions for “non-healing fracture” and “complex fracture.”

Proposed 1.00O – How do we determine your soft tissue injury or abnormality or your upper extremity fracture is no longer under continuing surgical management or you have received maximum therapeutic benefit?

We propose to replace the content of current 1.00O Major function of the face and head with guidance about determining when a soft tissue injury or abnormality or upper extremity fracture is no longer under continuing surgical management. We also incorporate the provisions of current sections 1.00M Under continuing surgical management, 1.00N After maximum benefit from therapy has been achieved, and 1.00P When surgical procedures have been performed.

Proposed 1.00P – How do we evaluate the severity and duration of your established musculoskeletal disorder when there is no record of ongoing treatment?

We propose to replace the content of current 1.00P When surgical procedures have been performed with guidance about how we assess impairments when there is no longitudinal medical record. We explain that when the individual has not received ongoing treatment or has just begun treatment, we may ask the individual to attend a consultative examination. We also explain that we may be able to assess the severity and duration of the individual’s impairment based on the medical record and current evidence

alone. In this section, we incorporate guidance from current section 1.00H3 When there is no record of ongoing treatment.

Proposed 1.00R – How do we evaluate disorders that do not meet one of the musculoskeletal listings?

We propose to add a new section 1.00R with guidance explaining that if a person’s disorder does not meet or medically equal the criteria of any of these listings, we will consider whether it meets or medically equals the criteria for a listing in another body system. We explain that if an impairment does not meet or medically equal any listing, we will assess the person’s residual functional capacity (RFC) and determine whether the person is capable of performing past work or adjusting to other work in the national economy. We also cite the rules we use when we determine whether a person continues to be disabled. In this section, we incorporate guidance from current section 1.00H4 Evaluation when the criteria of a musculoskeletal listing are not met.

V. What changes are we proposing to the musculoskeletal listings for adults?

We propose to revise the name of the body system from “Musculoskeletal System” to “Musculoskeletal Disorders.”

We propose to rename the headings of the listings and to renumber the listings in a more logical order, beginning with disorders of the spine, as those are the most

frequently used; moving outward physically to the extremities; and then to skeletal or soft tissue injuries. When these rules become final, renumbering the listings should make it easier for us to keep track of data trends for specific types of impairments over time. It should also help to prevent confusion in identifying or referring to prior listings after we publish a final rule.

We propose to present the overall structure of the listings in an outline form to make the rules more readily accessible to the reader. The following chart provides a comparison of the current and the proposed adult listings:

Current Listing	Proposed Listing
1.02 <u>Major dysfunction of a joint(s) (due to any cause)</u>	1.02 Removed without replacement
1.03 <u>Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint</u>	1.03 Removed without replacement
1.04 <u>Disorders of the spine</u>	1.04 Removed without replacement
1.05 <u>Amputation (due to any cause)</u>	1.05 Removed without replacement
1.06 <u>Fracture of the femur, tibia, pelvis, or one or more of the tarsal bones</u>	1.06 Removed without replacement
1.07 <u>Fracture of an upper extremity</u>	1.07 Removed without replacement
1.08 <u>Soft tissue injury (e.g., burns)</u>	1.08 Removed without replacement
	1.15 <u>Disorders of the skeletal spine resulting in compromise of a nerve root(s)</u>
	1.16 <u>Lumbar spinal stenosis resulting in compromise of the cauda equina</u>
	1.17 <u>Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint</u>
	1.18 <u>Abnormality of a major joint(s) in any extremity</u>
	1.19 <u>Pathologic fractures due to any cause</u>

	1.20 <u>Amputation due to any cause</u>
	1.21 <u>Soft tissue injury or abnormality under continuing surgical management</u>
	1.22 <u>Non-healing or complex fracture of the femur, tibia, pelvis, or one or more of the tarsal bones</u>
	1.23 <u>Non-healing or complex fracture of an upper extremity</u>

All of the proposed musculoskeletal listings contain multiple criteria. We distinguish whether all of the criteria must be met in order to meet that specific listing or just one of the criteria must be met in order to meet that specific listing by using a capital “AND” or “OR,” respectively. The “AND” or “OR” sit on a line independently on the left margin. We also distinguish whether all sub-criteria must be met or just one of the sub-criteria must be met in order to satisfy the relevant criteria by using a lowercase “and” or “or,” respectively.

1.15 Disorders of the skeletal spine resulting in compromise of a nerve root(s)

Proposed 1.15 Disorders of the skeletal spine resulting in compromise of a nerve root(s) incorporates and clarifies the provisions of current 1.04A for evidence of nerve root compression. In proposed 1.15 we have removed references to the particular disorders associated with compromise of a nerve root(s) and discussion of the tests used to demonstrate them. We have incorporated the references to specific disorders in the introductory text because they are examples of possible causative agents, whereas the listing addresses the effects of those agents on the nerve root(s). We have also removed the sign of atrophy from the listing because medical research and our experience does not

show atrophy necessarily correlates with any given level of functioning. We have provided for consideration of limitation of motion by evaluating the physical limitation of musculoskeletal functioning it causes using the new functional criteria. Under proposed criterion 1.15B for radicular neurological signs, we have included muscle weakness and sensory changes. We have also added the requirement for “[d]eep tendon reflexes” to the criterion because it is a manifestation of the disorder and illustrates our intentions for this listing. A criterion for imaging, which is not explicitly required in current 1.04A, has been added as proposed 1.15C “Findings on imaging consistent with compromise of a nerve root(s)” because it is a component necessary to establishing the disorder.

1.16 Lumbar spinal stenosis resulting in compromise of the cauda equina

Proposed 1.16 Lumbar spinal stenosis resulting in compromise of the cauda equina incorporates and clarifies the provisions of current 1.04C for lumbar spinal stenosis resulting in pseudoclaudication. We incorporate each of the requirements in current 1.04C into sections A–D of the proposed listing and clarify the current requirements with specific information in sections A–C. We have made a separate listing for compromise of the cauda equina due to the effects of lumbar spinal stenosis, because the symptoms and signs of this disorder differ from those of other nerve root(s) disorders and are not typically associated with a specific nerve root(s).

1.17 Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint

Proposed 1.17 Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint incorporates and clarifies the provisions of current listing 1.03 Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint.

1.18 Abnormality of a major joint(s) in any extremity

Proposed 1.18 Abnormality of a major joint(s) in any extremity incorporates and clarifies the provisions of current listings 1.02 Major dysfunction of a joint(s) (due to any cause). It includes the criteria from current 1.02 for evaluating dysfunction of any of the major joints in either the upper or lower extremities, or both, whether due to anatomical deformity, pain, or abnormal motion. We removed the terms “peripheral” and “weight-bearing,” which are in the current listing for major joint disorders (1.02 Major dysfunction of a joint(s) (due to any cause)), because proposed 1.18 covers all major joints in any extremity, making those distinctions unnecessary.

1.19 Pathologic fractures due to any cause

Proposed 1.19 Pathologic fractures due to any cause is a new listing that covers pathologic fractures of any part of the musculoskeletal system. Medical treatment and recovery expectations for fractures differ, depending on whether the condition is due to an underlying pathology (such as osteoporosis), or to a traumatic event. For this reason, we propose a separate listing for fractures caused by an underlying pathology in order to

provide specific criteria related to their evaluation and adjudication. We propose to evaluate complex or non-healing traumatic fractures under proposed 1.22 Non-healing or complex fracture of the femur, tibia, pelvis, or one or more of the tarsal bones or 1.23 Non-healing or complex fracture of an upper extremity.

1.20 Amputation due to any cause

Proposed 1.20 Amputation due to any cause incorporates and clarifies the provisions of current 1.05 Amputation (due to any cause). Proposed 1.20B for hemipelvectomy or hip disarticulation corresponds to current 1.05D for hemipelvectomy or hip disarticulation. In proposed 1.20A for amputation of both upper extremities and 1.20B for hemipelvectomy or hip disarticulation, we do not include any functional criteria, because we presume that a person with a disorder under either proposed 1.20A or 1.20B has limitations that satisfy one or more of the functional criteria in 1.00E2 and meet the duration requirement.

1.21 Soft tissue injury or abnormality under continuing surgical management

Proposed 1.21 Soft tissue injury or abnormality under continuing surgical management revises current listing 1.08 Soft tissue injury (e.g., burns). This proposed listing is consistent with our long-standing recognition that extensive, prolonged treatment in order to re-establish or improve function of the affected body part(s) may contribute to an inability to perform work-related activity.

It encompasses any abnormality of, or injury (including burns) to soft tissue that is under continuing surgical management directed toward saving, reconstructing, or replacing the affected part of the body. In proposed 1.21, we do not include any functional criteria because the prescribed surgical procedures treatments typically require a series of documented interventions over extended periods, which render the person unable to perform work-related activity on a sustained basis.

1.22 Non-healing or complex fracture of the femur, tibia, pelvis, or one or more of the tarsal bones

Proposed 1.22 Non-healing or complex fracture of the femur, tibia, pelvis, or one or more of the tarsal bones incorporates and clarifies the provisions of current listing 1.06 Fracture of the femur, tibia, pelvis, or one or more of the tarsal bones.

1.23 Non-healing or complex fracture of an upper extremity

Proposed 1.23 Non-healing or complex fracture of an upper extremity incorporates and clarifies the provisions of current listing 1.07 Fracture of an upper extremity.

VI. What changes are we proposing to the introductory text of the musculoskeletal disorders listings for children?

The same basic rules for evaluating musculoskeletal disorders in adults apply to the evaluation of such disorders in children. Except for changes in the introductory text specific to children, we propose to repeat most of the introductory text of proposed 1.00 Musculoskeletal Disorders in the introductory text of proposed 101.00 Musculoskeletal Disorders. Since we have already described these proposed revisions in the introductory text of proposed 1.00, we describe here only those sections of the proposed 101.00 rules that are unique to children or that require further explanation.

The following chart shows the headings of the current and proposed sections of the childhood introductory text:

Current Introductory Text	Proposed Introductory Text
A. <u>Disorders of the musculoskeletal system</u>	A. <u>Which disorders do we evaluate under these listings?</u>
B. <u>Loss of Function</u>	B. <u>Which related disorders do we evaluate under other listings?</u>
C. <u>Diagnosis and Evaluation</u>	C. <u>What evidence do we need to evaluate your musculoskeletal disorder under these listings?</u>
D. <u>The physical examination</u>	D. <u>How do we consider symptoms, including pain, under these listings?</u>
E. <u>Examination of the Spine</u>	E. <u>How do we use the functional criteria under these listings?</u>
F. <u>Major joints</u>	F. <u>What do we consider when we evaluate disorders of the skeletal spine resulting in compromise of a nerve root(s) (101.15)?</u>
G. <u>Measurements of joint motion</u>	G. <u>What do we consider when we evaluate lumbar spinal stenosis resulting in compromise of the cauda equina (101.16)?</u>
H. <u>Documentation</u>	H. <u>What do we consider when we evaluate reconstructive surgery or surgical arthrodesis of a major weight-bearing joint (101.17)?</u>
I. <u>Effects of Treatment</u>	I. <u>What do we consider when we evaluate abnormality of a major joint(s) in any</u>

	<u>extremity (101.18)?</u>
J. <u>Orthotic, Prosthetic, or Assistive Devices</u>	J. <u>What do we consider when we evaluate pathologic fractures due to any cause (101.19)?</u>
K. <u>Disorders of the spine</u>	K. <u>What do we consider when we evaluate amputation due to any cause (101.20)?</u>
L. <u>Abnormal curvatures of the spine</u>	L. <u>What do we consider when we evaluate soft tissue injury or abnormality under continuing surgical management (101.21)?</u>
M. <u>Under continuing surgical management</u>	M. <u>What do we consider when we evaluate non-healing or complex fractures of the femur, tibia, pelvis, or one or more of the tarsal bones (101.22)?</u>
N. <u>After maximum benefit from therapy has been achieved</u>	N. <u>What do we consider when we evaluate non-healing or complex fractures of an upper extremity (101.23)?</u>
O. <u>Major function of the face and head</u>	O. <u>What do we consider when we evaluate musculoskeletal disorders of infants and toddlers from birth to attainment of age 3 with developmental motor delay (101.24)?</u>
P. <u>When surgical procedures have been performed</u>	P. <u>How do we determine when your soft tissue injury or abnormality, or your upper extremity fracture, is no longer under continuing surgical management or you have received maximum therapeutic benefit?</u>
	Q. <u>How do we evaluate the severity and duration of your established musculoskeletal disorder when there is no record of ongoing treatment?</u>
	R. <u>How do we evaluate disorders that do not meet one of the musculoskeletal listings?</u>

VII. What changes are we proposing to the musculoskeletal disorders listings for children?

We propose to revise the name of the body system from “Musculoskeletal System” to “Musculoskeletal Disorders.”

We propose to add 101.24 Musculoskeletal disorders of infants and toddlers, from birth to attainment of age 3, with developmental motor delay. This listing evaluates developmental motor delay due to a musculoskeletal medically determinable impairment as a functional criterion for infants and toddlers. We propose to move the requirement of developmental motor skills that are no greater than one-half of the expected age performance from current 101.00B2c(2) How we assess inability to perform fine and gross movements in very young children into proposed 101.24. Proposed 101.24 does not have an adult counterpart.

We propose to use functional criteria for children that are the same as the criteria for adults.

The following chart provides a comparison of the current childhood listings and the proposed childhood listings:

Current childhood listings	Proposed childhood listings
101.02 <u>Major dysfunction of a joint(s) (due to any cause)</u>	101.02 Removed without replacement
101.03 <u>Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint</u>	101.03 Removed without replacement
101.04 <u>Disorders of the spine</u>	101.04 Removed without replacement
101.05 <u>Amputation (due to any cause)</u>	101.05 Removed without replacement
101.06 <u>Fracture of the femur, tibia, pelvis, or one or more of the tarsal bones</u>	101.06 Removed without replacement
101.07 <u>Fracture of an upper extremity</u>	101.07 Removed without replacement
101.08 <u>Soft tissue injury (e.g., burns)</u>	101.08 Removed without replacement

	101.15 <u>Disorders of the skeletal spine resulting in compromise of a nerve root(s)</u>
	101.16 <u>Lumbar spinal stenosis resulting in compromise of the cauda equina</u>
	101.17 <u>Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint</u>
	101.18 <u>Abnormality of a major joint(s) in any extremity</u>
	101.19 <u>Pathologic fractures due to any cause</u>
	101.20 <u>Amputation due to any cause</u>
	101.21 <u>Soft tissue injury or abnormality under continuing surgical management</u>
	101.22 <u>Non-healing or complex fracture of the femur, tibia, pelvis, or one or more of the tarsal bones</u>
	101.23 <u>Non-healing or complex fracture of an upper extremity</u>
	101.24 <u>Musculoskeletal disorders of infants and toddlers, from birth to attainment of age 3, with developmental motor delay</u>

As is the case with adults, for children, all of the proposed musculoskeletal listings contain multiple criteria. We distinguish whether all of the criteria must be met in order to meet that specific listing or just one of the criteria must be met in order to meet that specific listing by using a capital “AND” or “OR,” respectively. The “AND” or “OR” sit on a line independently on the left margin. We also distinguish whether all sub-criteria must be met or just one of the sub-criteria must be met in order to satisfy the relevant criteria by using a lowercase “and” or “or,” respectively.

VIII. Other changes

We propose to make conforming changes to current sections 4.00G4 What is lymphedema and how will we evaluate it? and 104.00F9 What is lymphedema and how will we evaluate it? of the cardiovascular system listings to indicate that we may evaluate whether lymphedema medically equals proposed listings 1.18 and 101.18 Abnormality of a major joint(s) in any extremity.

We propose to make conforming changes to the introductory text and listing criteria for immune system disorders. Many disorders of the immune system affect the musculoskeletal system; therefore, we are making these revisions to reflect this relationship and ensure consistency in our evaluation of musculoskeletal functioning. In 14.00C Definitions and 114.00C Definitions, we propose to provide explanations of terms for evaluating immune system disorders consistent with those we propose for evaluating musculoskeletal disorders. We propose to add definitions for “assistive device(s),” “documented medical need,” “fine and gross movements,” and “hand-held assistive device.” We also propose to replace “major peripheral joints” with “major joint of an upper or lower extremity,” to revise the explanation of that term, and to remove the terms “inability to ambulate effectively” and “inability to perform fine and gross movements effectively” for consistency with the proposed musculoskeletal disorders listings.

We propose to revise the information in current sections 14.00D4 Polymyositis and dermatomyositis (14.05) and 114.00D4 “Polymyositis and dermatomyositis (114.05)” describing how we evaluate polymyositis and dermatomyositis in motor skills

of newborns, younger infants, children, and adults. We propose to revise these sections for consistency with the proposal to remove the term “unable to ambulate effectively.” We propose to replace “ambulate effectively” with “walk without physical or mechanical assistance.”

We propose to make editorial changes to current sections 14.00D6 Inflammatory arthritis (14.09) and 114.00D6 Inflammatory arthritis (114.09). We propose to replace “major peripheral joints” with “major joints in an upper or lower extremity,” “ambulation or fine and gross movements” with “walking or performing fine and gross movements,” and “ambulation or the performance of fine and gross movements” with “walking or performing fine and gross movements.”

We propose to make conforming changes to describe listing-level severity in proposed listing criteria 14.09A and 114.09A “Persistent inflammation or persistent deformity” as follows: we propose to replace “an impairment that results in an ‘extreme’ (very serious) limitation” with “the presence of an impairment-related, significant limitation cited in the criteria of these listings.” We propose to replace “one major peripheral weight-bearing joint resulting in the inability to ambulate effectively” with “one major joint in a lower extremity resulting in a documented medical need for a walker, bilateral canes, or bilateral crutches.” We propose to replace “one major peripheral joint in each upper extremity resulting in the inability to perform fine and gross movements effectively” with “one major joint in each upper extremity resulting in

an impairment-related, significant limitation in the ability to perform fine and gross movements.”

To describe listing-level severity in current listing criteria 14.09C and 114.09 C “Ankylosing spondylitis or other spondyloarthropathies” we propose to replace “extreme limitation” with “impairment-related significant limitation” and “inability to ambulate effectively” with “a documented medical need for a walker, bilateral canes, or bilateral crutches.”

To describe listing-level severity in current listing criteria 14.09B, C, and D and 114.09B and C for impairments due to inflammatory arthritis, we also propose to replace “major peripheral joints” with “major joints in an upper or lower extremity.”

We propose to revise current section 114.00J2b “Musculoskeletal involvement, such as surgical reconstruction of a joint, under 101.00” to indicate that we may evaluate immune system disorders in children involving developmental motor delay under 101.00 Musculoskeletal Disorders.

We propose conforming changes to current immune system disorders listings 14.04 Systemic sclerosis (scleroderma), 14.05 Polymyositis and dermatomyositis, 14.09 Inflammatory arthritis, 114.04 Systemic sclerosis (scleroderma), 114.05 Polymyositis and dermatomyositis and 114.09 Inflammatory arthritis. In proposed 14.04 Systemic sclerosis (scleroderma), 14.05 Polymyositis and dermatomyositis, and 14.09 Inflammatory arthritis

for adults, we would replace “inability to ambulate effectively” with the requirement of one of the following:

- A documented medical need for a walker, bilateral canes, or bilateral crutches;
- or
- An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements, and a documented medical need for a one-handed assistive device that requires the use of the other upper extremity.

In proposed 114.04 Systemic sclerosis (scleroderma), 114.05 Polymyositis and dermatomyositis, and 114.09 Inflammatory arthritis for children, we would replace “inability to ambulate effectively” with the requirement of one of the following:

- A documented medical need for a walker, bilateral canes, or bilateral crutches;
- or
- An inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements, and a documented medical need for a one-handed assistive device that requires the use of the other upper extremity.

In proposed 14.04 Systemic sclerosis (scleroderma), 14.05 Polymyositis and dermatomyositis, and 14.09 Inflammatory arthritis for adults, we would replace “inability to perform fine and gross movements effectively” with “inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements.”

In proposed 114.04 Systemic sclerosis (scleroderma), 114.05 Polymyositis and dermatomyositis, and 114.09 Inflammatory arthritis for children, we would replace “inability to perform fine and gross movements effectively” with “inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements.”

In proposed 14.09 Inflammatory arthritis and 114.09 Inflammatory arthritis, we would replace “major peripheral weight-bearing joints” with “major joints in a lower extremity(ies).” In proposed 14.09 Inflammatory arthritis and 114.09 Inflammatory arthritis, we would replace “major peripheral joints” with “major joints” or “major joints of an upper or lower extremity(ies),” as appropriate for the affected extremity(-ies).

We propose to remove the first and second examples in § 416.926a(m) of this chapter, Examples of impairments that functionally equal the listings. The first example is “[a]ny condition that is disabling at the time of onset, requiring continuing surgical management within 12 months after onset as a life-saving measure or for salvage or restoration of function, and such major function is not restored or is not expected to be

restored within 12 months after onset of this condition.” (See § 416.926a(m)(1) of this chapter.) We are removing this example because, at the time it was written, there were no specific criteria that considered the need for ongoing surgical management in the listings. The second example is “[e]ffective ambulation possible only with obligatory bilateral upper limb assistance.” (See § 416.926a(m)(2) of this chapter.) We are removing this example because several of the proposed childhood listings include a criterion considering “...a documented medical need for a walker, bilateral canes, or bilateral crutches” (that is, “obligatory bilateral upper limb assistance.”) With the inclusion of the proposed childhood listings, it will no longer be necessary to have these examples in the regulations.

IX. Administrative Matters

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

The Social Security Act authorizes us to make rules and regulations and to establish necessary and appropriate procedures to implement them.¹⁰

How long would these proposed rules be effective?

¹⁰ Sections 205(a), 702(a)(5), and 1631(d)(1).

If we publish these proposed rules as final rules, they will remain in effect for 5 years after the date they become effective, unless we extend them, or revise and issue them again.

Clarity of These Proposed Rules

Executive Order 12866, as supplemented by Executive Order 13563, requires each agency to write all rules in plain language. In addition to your substantive comments on these proposed rules, we invite your comments on how to make them easier to understand.

For example:

- Would more, but shorter, sections be better?
- Are the requirements in the rules clearly stated?
- Have we organized the material to suit your needs?
- Could we improve clarity by adding tables, lists, or diagrams?
- What else could we do to make the rules easier to understand?
- Do the rules contain technical language or jargon that is not clear?
- Would a different format make the rules easier to understand, e.g.,

grouping and order of sections, use of headings, paragraphing?

Anticipated Economic Impact of the Proposed Rules

Financial Classification of SSA's Regulations

Based on criteria established by OMB Circular A-4 and Executive Order 13771, we classify this rule as a “transfer rule.” Transfer rules do not create or impose novel costs; rather, they regulate the transfer of monetary payments from one group to another without affecting the total resources available to society.

Under our Old-Age, Survivors, and Disability Insurance program (OASDI), SSA's regulations govern the transfer of benefits payments to qualified workers primarily from revenues collected from payroll taxes (FICA) and self-employment taxes (SECA). Under the Supplemental Security Income (SSI) program, funded by general tax revenues, SSA makes payments to individuals with limited income and resources who are aged, blind, or disabled.

This proposed rule establishes eligibility criteria for transferring disability payments to those persons who qualify for such payments based on the presence of a musculoskeletal body system disorder.

Anticipated Accounting Costs of these Proposed Rules

Anticipated Costs to Our Programs

For fiscal years (FY) 2018-2022, our Office of the Chief Actuary estimates that this proposed rule, once finalized, may result in a reduction of \$57,000,000 to our OASDI program costs, and an increase of \$11,000,000 to our SSI program costs. It is important to note that due to the roughly offsetting estimated effects of changes from allowance to denial and from denial to allowance, the true net effect for either program, OASDI or SSI, could potentially be either a small cost or a small saving.

Anticipated Administrative Costs to the Social Security Administration

In calculating whether the implementation of this proposed rule, once finalized, may result in administrative costs or savings to the agency, we examine two sources: 1) work-years and 2) direct financial administrative costs.

We define work-years as a measure of the SSA employee work time a proposed rule will cost or save during implementation of its policies. We calculate one work-year as 2,080 hours of labor, which represents the amount of hours one SSA employee works per year based on a standard 40-hour workweek.

We estimate the direct financial administrative costs of a proposed rule by examining requirements stemming from new regulations, including systems start-up and maintenance costs, operational costs resulting from new workloads, and internal training costs for relevant agency staff and adjudicators. To assess savings resulting from a proposed rule, we examine Systems and operational workload changes.

Based on the above factors, our Office of Budget, Finance, and Management estimates that implementation of these proposed rules, upon finalization, will result in overall administrative savings for SSA of fewer than 15 work-years and less than \$2 million annually for the period of FY 2018-2022.

When will we start to use these rules?

We will not use these rules until we evaluate public comments and publish final rules in the Federal Register. All final rules we issue include an effective date. We will continue to use our current rules until that date. If we publish final rules, we will include a summary of those relevant comments we received along with responses and an explanation of how we will apply the new rules.

Regulatory Procedures

Executive Order 12866, as supplemented by Executive Order 13563

We consulted with the Office of Management and Budget (OMB) and determined that this notice of proposed rulemaking (NPRM) meets the criteria for a significant regulatory action under Executive Order 12866, as supplemented by Executive Order 13563. Therefore, OMB reviewed it.

Regulatory Flexibility Act

We certify that this NPRM will not have a significant economic impact on a substantial number of small entities because it affects individuals only. Therefore, a regulatory flexibility analysis is not required under the Regulatory Flexibility Act, as amended.

Paperwork Reduction Act

These proposed rules do not create any new or affect any existing collections and, therefore, do not require OMB approval under the Paperwork Reduction Act.

X. References

We consulted the following references when we developed these proposed rules:

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We included these references in the rulemaking record for these proposed rules and will make them available for inspection by interested individuals who make arrangements with the contact person identified above.

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

List of Subjects

20 CFR Part 404

Administrative practice and procedure; Blind, Disability benefits; Old-Age, survivors, and disability insurance; Reporting and recordkeeping requirements; Social Security.

20 CFR Part 416

Administrative practice and procedure, Blind, Disability benefits, Public assistance programs, Reporting and recordkeeping requirements, Supplemental Security Income (SSI).

Nancy A. Berryhill,
Acting Commissioner of Social Security.

For the reasons set out in the preamble, we propose to amend 20 CFR, chapter III, part 404, subpart P as set forth below:

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

Subpart P—[Amended]

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

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

2. Amend appendix 1 to subpart P of part 404 as follows:

- a. Revise item 2 of the introductory text before part A;

- b. Amend part A by revising the body system name for section 1.00 in the table of contents;

c. Revise section 1.00 of part A;

d. Revise the second sentence of paragraph 4.00G4b of part A;

e. Redesignate current 14.00C2 through 14.00C12 of part A as follows:

Old section	New section
14.00C2	14.00C3
14.00C3	14.00C4
14.00C4	14.00C6
14.00C5	14.00C7
14.00C6	14.00C8
14.00C7	14.00C9
14.00C8	14.00C10
14.00C9	14.00C11
14.00C10	14.00C12
14.00C11	14.00C13
14.00C12	14.00C14

f. Add new paragraphs 14.00C2 and 14.00C5 to part A;

g. Revise 14.00C8 through 14.00C10;

h. Revise the first sentence of paragraph 14.00D4c(i) of part A;

i. Revise the second and third sentences of paragraph 14.00D6a of part A;

j. Revise paragraph 14.00D6e(i) and the first sentence of 14.00D6e(ii) of part A;

k. Revise 14.04B, 14.04C2, and 14.05A of part A;

l. Revise 14.09A and the first sentence of 14.09B of part A;

m. Amend part B by revising the body system name for section 101.00 in the table of contents;

n. Revise section 101.00 of part B;

o. Revise the second sentence of paragraph 104.00F9b of part B;

p. Redesignate current 114.00C2 through 114.00C12 of part B as follows:

Old section	New section
114.00C2	114.00C3
114.00C3	114.00C4
114.00C4	114.00C6
114.00C5	114.00C7
114.00C6	114.00C8
114.00C7	114.00C9
114.00C8	114.00C10
114.00C9	114.00C11
114.00C10	114.00C12
114.00C11	114.00C13
114.00C12	114.00C14

q. Add new paragraphs 114.00C2 and 114.00C5 to part B;

r. Revise 114.00C8 through 114.00C10;

s. Revise the first sentence of paragraph 114.00D4c(ii) of part B;

t. Revise the second and third sentences of paragraph 114.00D6a of part B;

u. Revise paragraph 114.00D6e(i) and the first sentence of 114.00D6e(ii) of part B;

v. Revise listings 114.04B, 114.04C2, and 114.05A of part B; and

w. Revise 114.09A and the heading of 114.09B of part B.

The revisions read as follows:

APPENDIX 1 TO SUBPART P OF PART 404—LISTING OF IMPAIRMENTS

* * * * *

2. Musculoskeletal Disorders (1.00 and 101.00): [THIS EXPIRES 5 YEARS FROM THE EFFECTIVE DATE OF THE FINAL RULES].

* * * * *

Part A

* * * * *

1.00 Musculoskeletal Disorders.

* * * * *

1.00 MUSCULOSKELETAL DISORDERS

A. Which disorders do we evaluate under these listings?

1. We evaluate disorders of the skeletal spine (vertebral column) or of the upper or lower extremities that affect musculoskeletal functioning in the musculoskeletal body system listings. We use the term “skeletal” when we are referring to the structure of the bony skeleton. The skeletal spine refers to the bony structures, ligaments, and discs making up the spine. We refer to the “skeletal” spine in some musculoskeletal listings to differentiate it from the neurological spine (see 1.00B1). Disorders may be congenital or acquired, and may include deformities, amputations, or other musculoskeletal abnormalities. These disorders may involve the bones or major joints; or the tendons, ligaments, muscles, or other soft tissues.

2. We also evaluate soft tissue abnormalities or injuries (including burns) that are under continuing surgical management (see 1.00L1). The abnormalities or injuries may affect any part of the body, including the face and skull.

B. Which related disorders do we evaluate under other listings?

1. We evaluate a disorder or injury of the skeletal spine that results in damage to, and neurological dysfunction of, the spinal cord and its associated nerves (for example, paraplegia or quadriplegia) under the criteria in 11.00 Neurological Disorders.

2. We evaluate inflammatory arthritis (for example, rheumatoid arthritis) under the criteria in 14.00 Immune System Disorders.

3. We evaluate curvatures of the skeletal spine under these musculoskeletal disorders listings and other listings as appropriate for the affected body system. Curvatures of the skeletal spine that affect musculoskeletal functioning are evaluated under 1.15 Disorders of the skeletal spine resulting in compromise of a nerve root(s). If a curvature of the skeletal spine is under continuing surgical management, we can evaluate it for medical equivalence to 1.21 Soft tissue injury or abnormality under continuing surgical management. Curvatures of the skeletal spine may also adversely affect functioning in body systems other than the musculoskeletal system. For example, the curvature may interfere with your ability to breathe (see 3.00 Respiratory Disorders); there may be impaired myocardial function (see 4.00 Cardiovascular System); or there may be disfigurement resulting in social withdrawal or depression (see 12.00 Mental Disorders).

4. We evaluate non-healing or pathological fractures due to cancer, whether it is a primary site or metastases, under the criteria in 13.00 Cancer (Malignant Neoplastic Diseases).

5. We evaluate the leg pain associated with peripheral vascular claudication, as well as diabetic foot ulcers, under the criteria in 4.00 Cardiovascular System.

6. We evaluate burns that do not require continuing surgical management under the criteria in 8.00 Skin Disorders.

C. What evidence do we need to evaluate your musculoskeletal disorder under these listings?

1. General. To establish the presence of a musculoskeletal disorder as a medically determinable impairment, we need objective medical evidence from an acceptable medical source who has examined you for the disorder. To assess the severity and duration of your disorder, we evaluate evidence from both medical and nonmedical sources who can describe how you function. If there is no record of ongoing medical treatment for your disorder, we will follow the guidelines in 1.00P How do we evaluate the severity and duration of your established musculoskeletal disorder when there is no record of ongoing treatment? We will determine the extent and kinds of evidence we need from medical and non-medical sources based on the individual facts about your disorder. For our basic rules on evidence, see §§ 404.1502, 404.1512, 404.1513,

404.1513a, 404.1520b, 416.902, 416.912, 416.913, 416.913a, and 416.920b of this chapter. For our rules on evidence about your symptoms, see §§ 404.1529 and 416.929 of this chapter.

2. Physical examination report(s). In the report(s) of your physical examination, we need a detailed description of the orthopedic, neurologic, or other objective clinical findings appropriate to your specific musculoskeletal disorder. We require objective clinical findings from the medical source's direct observations during your physical examination, not simply his or her report of your statements about your symptoms and limitations. When the medical source reports that a clinical test sign(s) is positive, unless we have evidence to the contrary, we will assume that he or she performed the test properly. For instance, we will assume a straight-leg raising test was conducted properly, i.e., in a sitting and supine position, even if the medical source does not specify the positions in which the test was performed. In the absence of evidence to the contrary, we will accept the medical source's interpretation of the test. If you use an assistive device (see 1.00C6), the report must support the medical need for the device. If reduction in muscle strength is a factor, we require medical documentation of measurement of the strength of the muscle(s) in question, generally based on a grading system of 0 to 5. Zero (0) indicates complete loss of strength and 5 indicates maximum strength, consistent with Table 1 below. The documentation should also include measurements of grip and pinch strength, if there is evidence of involvement of one or both hands.

Table 1

Grading Scale of Muscle Function: 0 to 5		
0	None	No visible or palpable contraction
1	Trace	Visible or palpable contraction with no motion
2	Poor	Active range of motion (ROM) with gravity eliminated
3	Fair	Active ROM against gravity only, without resistance
4	Good	Active ROM against gravity, moderate resistance
5	Normal	Active ROM against gravity, maximum resistance

3. Laboratory findings: Imaging and other diagnostic tests

a. Imaging refers to medical imaging techniques, such as x-ray, computed tomography (CT), magnetic resonance imaging (MRI), and radionuclide scanning. For the purpose of these listings, the imaging technique(s) must be consistent with the generally accepted standards of medical knowledge and clinical practice.

b. Findings on imaging must have lasted, or must be expected to last, for a continuous period of at least 12 months.

c. Imaging and other diagnostic tests can provide evidence of physical abnormalities; however, they may correlate poorly with your symptoms, including pain, or with your musculoskeletal functioning. Accordingly, we cannot use such tests as a substitute for physical examination findings about your ability to function, nor can we infer severity or functional limitations based solely on such tests.

d. For our policies about when we will purchase imaging and other diagnostic tests, see §§ 404.1519k, 404.1519m, 416.919k, and 416.919m of this chapter.

4. Operative reports. If you have had a surgical procedure(s), we need either the operative reports, including details of the findings at surgery and information about any medical complications that may have occurred, or confirmatory evidence of the surgical procedure(s) from a medical source (for example, detailed follow-up reports or notations in the medical records concerning your past medical history).

5. Effects of treatment

a. General. Treatments for musculoskeletal disorders may have beneficial or adverse effects, and responses to treatment vary from person to person. We will evaluate all of the effects of treatment (including surgical treatment, medications, and therapy) on the symptoms, signs, and laboratory findings of your musculoskeletal disorder, and on your musculoskeletal functioning.

b. Response to treatment. To evaluate your musculoskeletal functioning in response to treatment, we need specific information related to your impairment, including the following: a description of your medications, including frequency of administration; the type and frequency of therapy you receive; and a description of your response to treatment and any complications you experience related to your impairment. The effects of treatment may be temporary or long-term. We need information over a sufficient period to determine the effect of treatment on your current musculoskeletal functioning and to permit reasonable projections about your future functioning. In some cases, we

will need additional evidence to make an assessment about your response to treatment. Depending upon the timing of this treatment in relation to the alleged onset date of disability, we may need to defer evaluation of the impairment for a period of up to 3 months from the date treatment began to permit consideration of treatment effects, unless we can make a determination or decision using the evidence we have.

6. Assistive devices

a. General. An assistive device, for the purposes of these listings, is any device that is used to improve stability, dexterity, or mobility. An assistive device can be worn (see 1.00C6b and c), or hand-held (see 1.00C6d). If you use any type of assistive device(s), we need evidence from a medical source regarding the documented medical need for the device(s). When we use the term “documented medical need,” we mean that there is evidence from a medical source(s) in the medical record that supports your need for an assistive device (see §§ 404.1513 and 416.913 of this chapter). The evidence must include documentation from a medical source(s) describing any limitation(s) in your upper or lower extremity functioning that supports your need for the assistive device(s), and the circumstances for which you need it. The evidence does not have to include a specific prescription for the device(s).

b. Prosthesis(es). A prosthesis is a wearable device, such as an artificial limb, that takes the place of an absent body part. We need evidence from a medical source documenting your ability to walk, or to perform fine and gross movements (see 1.00E3),

with the prosthesis(es) in place. When amputation(s) involves a lower extremity or extremities, it is not necessary to evaluate your ability to walk without the prosthesis(es) in place. If you cannot use your prosthesis(es) due to complications affecting your residual limb(s), we need documentation from a medical source regarding the condition of your residual limb(s) and the medical basis for your inability to use the prosthesis(es).

c. Orthosis(es). An orthosis is a wearable device that prevents or corrects a dysfunction or deformity by aligning or supporting the affected body part. An orthosis may also be referred to as a “brace.” If you have an orthosis(es), we need evidence from a medical source documenting your ability to walk, or to perform fine and gross movements, with the orthosis(es) in place. If you cannot use your orthosis(es), we need evidence from a medical source documenting the medical basis for your inability to use the device(s).

d. Hand-held assistive devices. Hand-held assistive devices include canes, crutches, or walkers, and are carried in your hand(s) to support or aid you in walking. When you require a one-handed assistive device for ambulation, such as a cane or single crutch, and your other upper extremity has limitations preventing its use for fine or gross movement(s) (see 1.00E3), the need for the assistive device limits the use of both upper extremities. If you use a hand-held assistive device, we need evidence from a medical source documenting your need for the device(s) and describing how you walk with the device(s).

7. Longitudinal evidence

a. We generally need a longitudinal medical record to assess the duration of your musculoskeletal disorder, because symptoms, signs, and laboratory findings related to most musculoskeletal disorders may wax and wane, may improve over time, or may respond to treatment. By providing evidence over an extended period, the medical record will show whether your musculoskeletal functioning is improving, worsening, or unchanging.

b. For 1.19 Pathologic fractures due to any cause and 1.21 Soft tissue injury or abnormality under continuing surgical management, the required 12-month duration period is stated in the listing itself. For 1.20A (amputation of both upper extremities) or 1.20B (hemipelvectomy or hip disarticulation), we presume satisfaction of the duration requirement.

c. For all listings not referenced in 1.00C7b above, all of the required criteria must be present simultaneously, or within a close proximity of time, to satisfy the level of severity needed to meet the listing. When we use the term “close proximity of time,” we mean that all of the relevant criteria have to appear in the medical record within a period not to exceed 4 months of one another. When the criterion in question is imaging, we mean those findings on imaging that we could reasonably expect to have been present at the date of impairment or date of onset. To meet a listing that uses the word “and” or “AND” to link the elements of the required criteria, the medical record must establish the

simultaneous presence, or presence within a close proximity of time, of all the required medical criteria. Once this level of severity is established, the medical record must also show that this level of severity has continued, or is expected to continue, for a continuous period of at least 12 months.

8. Surgical treatment

For some musculoskeletal disorders, a medical source may recommend surgery. If you have not yet had the recommended surgery, we will not deny your claim based on an assumption that surgery will resolve or improve your disorder. We will assess each case on an individual basis. Depending on your response to treatment, or depending on your medical sources' treatment plans, we may defer our findings regarding the effect of surgical intervention until a sufficient period has passed to permit proper consideration or judgment about your future functioning. See 1.00C5b Response to treatment.

D. How do we consider symptoms, including pain, under these listings?

1. Individuals with musculoskeletal disorders may experience pain or other symptoms; however, statements alone about your pain or other symptoms cannot establish that you are disabled. Further, an alleged or reported increase in the intensity of a symptom, such as pain, no matter how severe, cannot be substituted for a medical sign or diagnostic finding present in the listing criteria. Pain is included as just one consideration in paragraph A in listings 1.15, 1.16, and 1.18, but is not required to satisfy

the criteria in these listings. Examples of other findings that will satisfy the criteria in paragraph A include muscle fatigue, nonradicular distribution of sensory loss in one or both extremities, and joint stiffness.

2. To consider your pain, we require objective medical evidence from an acceptable medical source showing the existence of a medically determinable impairment(s) (MDI) that could reasonably be expected to produce the pain. When your musculoskeletal MDI could reasonably be expected to produce the pain or other symptoms alleged, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with all of the objective medical evidence, including medical signs and laboratory or diagnostic findings. See §§ 404.1529 and 416.929 of this chapter for information on how we evaluate pain or other symptoms related to a musculoskeletal impairment.

E. How do we use the functional criteria under these listings?

1. General. We will determine that your musculoskeletal disorder meets a listing if it satisfies the medical criteria; includes at least one of the functional criteria, if included in the listing; and satisfies the 12-month duration requirement. We will use the relevant evidence that we have to evaluate your musculoskeletal functioning with respect to the work environment rather than the home environment. For example, an ability to walk independently at home without an assistive device does not, in and of itself, indicate an ability to walk without an assistive device in a work environment.

2. Functional criteria. The functional criteria are based on impairment-related physical limitations in your ability to use both upper extremities, one or both lower extremities, or a combination of one upper and one lower extremity. A musculoskeletal disorder satisfies the functional criteria of a listing when the medical documentation shows the presence of at least one of the impairment-related limitations cited in the listing. The required impairment-related physical limitation of musculoskeletal functioning must have lasted, or be expected to last, for a continuous period of at least 12 months, medically documented by one of the following:

a. A documented medical need (see 1.00C6a) for a walker, bilateral canes, or bilateral crutches (see 1.00C6d);

b. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 1.00E3), and a documented medical need (see 1.00C6a) for a one-handed assistive device (see 1.00C6d) that requires the use of your other upper extremity;

c. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 1.00E3).

3. Fine and gross movements. Fine movements, for the purposes of these listings, involve use of your wrists, hands, and fingers; such movements include picking, pinching, manipulating, and fingering. Gross movements involve use of your shoulders, upper arms, forearms, and hands; such movements include handling, gripping, grasping, holding, turning, and reaching. Gross movements also include exertional abilities such as lifting, carrying, pushing, and pulling. Examples of inability to perform fine and gross movements include, but are not limited to, the inability to take care of personal hygiene, the inability to sort and handle papers or files, and the inability to place files in a file cabinet at or above waist level.

4. When we do not use the functional criteria. We do not use the functional criteria to evaluate amputation of both upper extremities under 1.20A, hemipelvectomy or hip disarticulation under 1.20B, and soft tissue injuries or abnormalities under continuing surgical management under 1.21.

F. What do we consider when we evaluate disorders of the skeletal spine resulting in compromise of a nerve root(s) (1.15)?

1. General. We consider musculoskeletal disorders such as herniated nucleus pulposus, spinal osteoarthritis (spondylosis), vertebral slippage (spondylolisthesis), degenerative disc disease, facet arthritis, and vertebral fracture or dislocation. Spinal disorders may cause cervical or lumbar spine dysfunction when abnormalities of the

skeletal spine compromise nerve roots of the cervical spine, a nerve root of the lumbar spine, or a nerve root of both cervical and lumbar spines.

2. Compromise of a nerve root(s). Compromise of a nerve root(s), sometimes referred to as “nerve root impingement,” is a term used when a physical object is seen pushing on the nerve root in an imaging study or during surgery. Objects such as tumors, herniated discs, foreign bodies, or arthritic spurs may cause compromise of a nerve root. It can occur when a musculoskeletal disorder produces irritation, inflammation, or compression of the nerve root(s) as it exits the skeletal spine between the vertebrae. Related symptoms must be associated with, or follow the path of, the specific nerve root(s), thereby presenting a neuro-anatomic (usually referred to as “radicular”) distribution of symptoms and signs, including pain, paresthesia (for example, burning, prickling, or tingling), sensory loss, and usually muscle weakness specific to the affected nerve root(s).

a. Compromise of unilateral nerve root of the cervical spine. Compromise of a nerve root as it exits the cervical spine between the vertebrae may affect the functioning of the associated upper extremity. The clinical examination reproduces the related symptoms based on radicular signs and clinical tests (for example, a positive Spurling’s test) appropriate to the specific cervical nerve root.

b. Compromise of bilateral nerve roots of the cervical spine. Although uncommon, if compromise of a nerve root occurs on both sides of the cervical spinal column, functioning of both upper extremities may be limited.

c. Compromise of a nerve root(s) of the lumbar spine. Compromise of a nerve root as it exits the lumbar spine between the vertebrae may limit the functioning of the associated lower extremity. The clinical examination reproduces the related symptoms based on radicular signs and clinical tests. When a nerve root of the lumbar spine is compromised, we require a positive straight-leg raising test (also known as a Lasegue test) in both supine and sitting positions appropriate to the specific lumbar nerve root that is compromised. (See 1.00C2 for guidance on interpreting information from a physical examination report.)

G. What do we consider when we evaluate lumbar spinal stenosis resulting in compromise of the cauda equina (1.16)?

1. We consider the limiting effects of pain, sensory changes, and muscle weakness caused by compromise of the cauda equina due to lumbar spinal stenosis. The cauda equina is a bundle of nerve roots that descends from the lower part of the spinal cord. Lumbar spinal stenosis can compress the nerves of the cauda equina, causing sensory changes and muscle weakness that may affect your ability to stand or walk. Pain related to compromise of the cauda equina is “nonradicular,” because it is not typically associated with a specific nerve root (as is radicular pain in the cervical or lumbar spine).

2. Compromise of the cauda equina due to spinal stenosis can affect your ability to walk because of neurogenic claudication (also known as pseudoclaudication), a disorder usually causing non-radicular pain that starts in the low back and radiates bilaterally (or less commonly, unilaterally) into the buttocks and lower extremities (or extremity). Extension of the lumbar spine, as when walking or merely standing, provokes the pain of neurogenic claudication. It is relieved by forward flexion of the lumbar spine or by sitting. In contrast, the leg pain associated with peripheral vascular claudication results from inadequate arterial blood flow to a lower extremity. It occurs repeatedly and consistently when a person walks a certain distance and is relieved when the person rests.

H. What do we consider when we evaluate reconstructive surgery or surgical arthrodesis of a major weight-bearing joint (1.17)?

1. We consider reconstructive surgery or surgical arthrodesis when an acceptable medical source(s) documents the surgical procedure(s) and associated medical treatments to restore function of the affected body part(s). The reconstructive surgery may be a single event or it may be a series of procedures directed toward the salvage or restoration of functional use of the affected joint.

2. Major weight-bearing joints. The major weight-bearing joints are the hip, knee, and ankle-foot. The ankle and foot are considered together as one major joint.

3. Surgical arthrodesis. Surgical arthrodesis is the artificial fusion of the bones that form a joint, essentially eliminating the joint.

I. What do we consider when we evaluate abnormality of a major joint(s) in any extremity (1.18)?

1. General. We consider musculoskeletal disorders that produce anatomical abnormalities of major joints of the extremities, resulting in functional abnormalities in the upper or lower extremities (for example, osteoarthritis and chronic infections of bones and joints, surgical arthrodesis of a joint). Major joint of an upper extremity refers to the shoulder, elbow, and wrist-hand. We consider the wrist and hand together as one major joint. Major joint of a lower extremity refers to the hip, knee, and ankle-foot. We consider the ankle and hindfoot together as one major joint, because it is necessary for walking. Abnormalities affecting the joints may include ligamentous laxity or rupture, soft tissue contracture, or tendon rupture, and can cause muscle weakness of the affected body part.

2. How do we define abnormality in the extremities? An anatomical abnormality in any extremity(ies) is one that is readily observable by a medical source during a physical examination (for example, subluxation or contracture), or is present on imaging (for example, ankylosis, bony destruction, joint space narrowing, or deformity). A functional abnormality is abnormal motion or instability of the affected part(s), including limitation of motion, excessive motion (hypermobility), movement outside the normal

plane of motion for the joint (for example, lateral deviation), or fixation of the affected parts.

J. What do we consider when we evaluate pathologic fractures due to any cause (1.19)? We consider pathologic fractures of the bones in the skeletal spine, extremities, or other parts of the skeletal system. Pathologic fractures result from disorders that weaken the bones, making them vulnerable to breakage. For non-healing or complex traumatic fractures without accompanying pathology, see 1.22 Non-healing or complex fracture of the femur, tibia, pelvis, or one or more of the tarsal bones or 1.23 Non-healing or complex fracture of an upper extremity. Pathologic fractures may occur with osteoporosis, osteogenesis imperfecta or any other skeletal dysplasias, side effects of medications, and disorders of the endocrine or other body systems. They must occur on separate, distinct occasions, rather than multiple fractures occurring at the same time, but they may affect the same bone(s) multiple times. There is no required period between the incidents of fracture(s), but they must all occur within a 12-month period; for example, separate incidents may occur within hours or days of each other. However, the associated limitation(s) of function must last, or be expected to last, at least 12 months.

K. What do we consider when we evaluate amputation due to any cause (1.20)?

1. General. We consider amputation (the full or partial loss or absence of any extremity) due to any cause, including trauma, congenital abnormality or absence,

surgery for treatment of conditions such as cancer or infection, or complications of peripheral vascular disease or diabetes mellitus.

2. Amputation of both upper extremities (1.20A). Upper extremity amputations, for the purposes of this listing, may occur at any level above the wrists (carpal joints), up to and including disarticulation of the shoulder (glenohumeral) joint. We do not evaluate amputations below the wrists under this listing, because the resulting limitation of function of the thumb(s), finger(s), or hand(s) will vary, depending on the extent of loss and corresponding effect on fine and gross movements (see 1.00E3). For amputations below the wrist, we will follow the remaining steps of the sequential evaluation process (see §§ 404.1520 and 416.920 of this chapter).

3. Hemipelvectomy or hip disarticulation (1.20B). Hemipelvectomy involves amputation of an entire lower extremity through the sacroiliac joint. Hip disarticulation involves amputation of an entire lower extremity through the hip joint capsule and closure of the remaining musculature over the exposed acetabular bone.

4. Amputation of one upper extremity at any level above the wrist and one lower extremity at or above the ankle (1.20C). We evaluate the absence of one upper extremity and one lower extremity with regard to whether you have a documented medical need (see 1.00C6a) for a one-handed assistive device (see 1.00C6d), such as a cane or crutch. In this situation, you may wear a prosthesis (see 1.00C6b) on your lower extremity, but nevertheless have a documented medical need for a one-handed assistive device. If you

do, you would need to use your other upper extremity to hold the assistive device, making the extremity unavailable to perform other fine and gross movements (see 1.00E3) such as carrying. In such a case, your disorder would meet this listing.

5. Amputation of one or both lower extremities at or above the ankle (tarsal joint)

(1.20D). When we evaluate amputations of one or both lower extremities:

a. We consider the condition of your residual limb(s), and whether you can wear a prosthesis(es) (see 1.00C6b). When you have a prosthesis(es), we will examine your residual limb with the prosthesis(es) in place. If you are unable to use a prosthesis(es) because of residual limb complications that have lasted, or are expected to last, for at least 12 months, and you are not currently undergoing surgical management (see 1.00L) of your condition, we evaluate your disorder under this listing.

b. Under 1.20D “Amputation of one or both lower extremities at or above the ankle (tarsal joint),” we consider whether you have a documented medical need (see 1.00C6a) for a hand-held assistive device(s) (1.00C) and your ability to walk with the device(s).

c. If you have a non-healing residual limb(s) and are receiving ongoing surgical treatment expected to re-establish or improve function, and that ongoing surgical treatment has not ended, or is not expected to end, within at least 12 months of the

initiation of the surgical management (see 1.00L1), we evaluate your disorder under 1.21 Soft tissue injury or abnormality under continuing surgical management.

L. What do we consider when we evaluate soft tissue injuries or abnormalities under continuing surgical management (1.21)?

1. General.

a. We consider any soft tissue injury or abnormality involving the soft tissues of the body, whether congenital or acquired, when an acceptable medical source(s) documents the need for ongoing surgical procedures and associated medical treatments to restore function of the affected body part(s). Surgical management includes the surgery(-ies) itself, as well as various post-surgical procedures, surgical complications, infections or other medical complications, related illnesses, or related treatments that delay a person's attainment of maximum benefit from surgery.

b. Surgical procedures and associated treatments typically take place over extended periods, which may render you unable to perform work-related activity on a sustained basis. To document such inability, we must have evidence from an acceptable medical source(s) confirming that the surgical management has continued, or is expected to continue, for at least 12 months from the date of the first surgical intervention. These procedures and treatments must be directed toward saving, reconstructing, or replacing

the affected part of the body to re-establish or improve its function, and not for cosmetic appearances alone.

c. Examples include malformations, third and fourth degree burns, crush injuries, craniofacial injuries, avulsive injuries, and amputations with complications of the residual limb(s).

d. We evaluate skeletal spine abnormalities or injuries under 1.15 Disorders of the skeletal spine resulting in compromise of a nerve root(s), or 1.16 Lumbar spinal stenosis resulting in compromise of the cauda equina, as appropriate. We evaluate abnormalities or injuries of bones in the lower extremities under 1.17 Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint, 1.18 Abnormality of a major joint(s) in any extremity, or 1.22 Non-healing or complex fracture of the femur, tibia, pelvis, or one or more of the tarsal bones. We evaluate abnormalities or injuries of bones in the upper extremities under 1.18 Abnormality of a major joint(s) in any extremity, or 1.23 Non-healing or complex fracture of an upper extremity.

2. Documentation. In addition to the objective medical evidence we need to establish your soft tissue injury or abnormality, we also need all of the following medically documented evidence about your continuing surgical management:

a. Operative reports and related laboratory findings;

- b. Records of post-surgical procedures;
- c. Records of any surgical or medical complications (for example, related infections or systemic illnesses);
- d. Records of any prolonged post-operative recovery periods and related treatments (for example, surgeries and treatments for burns);
- e. An acceptable medical source's plans for additional surgeries; and
- f. Records detailing any other factors that have delayed, or that an acceptable medical source expects to delay, the saving, restoring, or replacing of the involved part for a continuous period of at least 12 months following the initiation of the surgical management.

3. Burns. Third- and fourth-degree burns damage or destroy nerve tissue, reducing or preventing transmission of signals through those nerves. Such burns frequently require multiple surgical procedures and related therapies to re-establish or improve function, which we evaluate under 1.21 Soft tissue injury or abnormality under continuing surgical management. When burns are no longer under continuing surgical management, we evaluate the residual impairment(s) (see 1.00O). When the residual impairment(s) affects the musculoskeletal system, as often occurs in third and fourth degree burns, it can result in permanent musculoskeletal tissue loss, joint contractures, or loss of extremities. We

will evaluate such impairments under the relevant musculoskeletal listing(s), for example, 1.18 Abnormality of a major joint(s) in any extremity or 1.20 Amputation due to any cause. When the residual impairment(s) involves another body system(s), we will evaluate the impairment(s) under the relevant body system listing (for example, 8.08 Burns).

4. Craniofacial injuries. Surgeons may treat craniofacial injuries with multiple surgical procedures. These injuries may affect vision, hearing, speech, and the initiation of the digestive process, including mastication. When the craniofacial injury-related residual impairment(s) involves another body system(s), we will evaluate the impairment(s) under the relevant body system listings. See 1.00O regarding evaluation of residual impairment(s).

M. What do we consider when we evaluate non-healing or complex fractures of the femur, tibia, pelvis, or one or more of the tarsal bones (1.22)?

1. We evaluate a non-healing (nonunion) or complex fracture of the femur, tibia, pelvis, or one or more of the tarsal bones with regard to whether you have a documented medical need (see 1.00C6a) for a bilateral (two-handed) assistive device (see 1.00C6d), such as a walker or bilateral crutches.

2. Non-healing fracture. A non-healing fracture is a fracture that has failed to unite completely. Nonunion is usually established when a minimum of 9 months has

elapsed since the injury and the fracture site has shown no progressive signs of healing for a minimum of 3 months.

3. Complex fracture. A fracture is complex when one or more of the following occur:

- a. Comminuted (broken into many pieces) bone fragments,
- b. Multiple fractures in a single bone,
- c. Bone loss due to severe trauma,
- d. Damage to the surrounding soft tissue,
- e. Severe cartilage damage to the associated joint, or
- f. Dislocation of the associated joint.

4. When a complex fracture involves soft tissue damage, the treatment may involve continuing surgical management to restore or improve functioning. In such cases, we may evaluate the fracture(s) under 1.21 Soft tissue injury or abnormality under continuing surgical management.

N. What do we consider when we evaluate non-healing or complex fractures of an upper extremity (1.23)?

1. We evaluate a non-healing (nonunion) or complex fracture of an upper extremity under continuing surgical management (see 1.00L1a) with regard to whether you have an inability to use both upper extremities to independently initiate, sustain, and complete fine and gross movements.

2. Non-healing fracture. A non-healing fracture is a fracture that has failed to unite completely. Nonunion is usually established when a minimum of 9 months have elapsed since the injury and the fracture site has shown no progressive signs of healing for a minimum of 3 months.

3. Complex fracture. A fracture is complex when one or more of the following occur:

- a. Comminuted (broken into many pieces) bone fragments,
- b. Multiple fractures in a single bone,
- c. Bone loss due to severe trauma,
- d. Damage to the surrounding soft tissue,

e. Severe cartilage damage to the associated joint, or

f. Dislocation of the associated joint.

O. How do we determine when your soft tissue injury or abnormality or your upper extremity fracture is no longer under continuing surgical management or you have received maximum therapeutic benefit?

1. Your soft tissue injury or abnormality or your upper extremity fracture is no longer under continuing surgical management when the last surgical procedure or medical treatment directed toward the re-establishment or improvement of function of the involved part has occurred. We will find that you have received maximum therapeutic benefit from treatment if there are no significant changes in physical findings or on appropriate imaging for any 6-month period after the last surgical procedure or medical treatment. We may also find that you have received maximum therapeutic benefit if your medical source(s) indicates that further improvement is not expected after the last surgical procedure or medical treatment.

2. When you have received maximum therapeutic benefit from treatment, we will evaluate any impairment-related residual symptoms, signs, and laboratory findings (including those on imaging), any complications associated with your surgical procedures or medical treatments, and any residual limitations in your functioning. Depending upon

all of those factors, we may find that your musculoskeletal impairment is no longer severe.

3. If your impairment(s) remains severe, we will evaluate your residual limitations and all other impairment-related factors to determine whether your musculoskeletal disorder meets or medically equals another listing. If it does not, we will follow the remaining steps of the sequential evaluation process to determine whether you have the residual functional capacity (RFC) to engage in substantial gainful activity. If your impairment involves burns and remains severe, we will follow the above sequence by evaluating your impairment as described in 1.00L3.

P. How do we evaluate the severity and duration of your established musculoskeletal disorder when there is no record of ongoing treatment?

1. You may not have received ongoing treatment or may not have an ongoing relationship with the medical community despite having a musculoskeletal disorder(s). In either of these situations, you will not have a longitudinal medical record for us to review when we evaluate your disorder. We may therefore ask you to attend a consultative examination to determine the severity and potential duration of your disorder (see §§ 404.1519a(b) and 416.919a(b) of this chapter).

2. In some instances, we may be able to assess the severity and duration of your musculoskeletal disorder based on your medical record and current evidence alone. If the

information in your case record is not sufficient or appropriate to show that you have a musculoskeletal disorder that meets the criteria of one of the musculoskeletal disorders listings, we will follow the rules in 1.00R.

Q. How do we evaluate substance use disorders that co-exist with a musculoskeletal disorder?

If we find that you are disabled and there is medical evidence in your case record establishing that you have a substance use disorder that co-exists with your musculoskeletal disorder, we will determine whether your substance use disorder is a contributing factor material to the determination of disability (see §§ 404.1535 and 416.935 of this chapter).

R. How do we evaluate disorders that do not meet one of the musculoskeletal listings?

1. These listings are only examples of musculoskeletal disorders that we consider severe enough to prevent your ability to engage in any gainful activity. If your musculoskeletal disorder(s) does not meet the criteria of any of these listings, we will consider whether you have an impairment(s) that meets the criteria of a listing in another body system.

2. If you have a severe medically determinable impairment(s) that does not meet any listing, we will determine whether your impairment(s) medically equals a listing. See §§ 404.1526 and 416.926 of this chapter. If it does not medically equal a listing, we will assess your RFC. See §§ 404.1545 and 416.945 of this chapter. To assess your RFC, we may require evidence in addition to, or different from, the types of evidence that we use to determine whether your impairment(s) meets or medically equals a listing. We will use the assessment of your RFC to evaluate your claim at the fourth, and if necessary, the fifth step of the sequential evaluation process to determine whether you can perform your past work or adjust to any other work, respectively. See §§ 404.1520 and 416.920 of this chapter.

3. We use the rules in §§ 404.1594 and 416.994 of this chapter, as appropriate, when we decide whether you continue to be disabled.

1.01 Category of Impairments, Musculoskeletal Disorders

1.15 Disorders of the skeletal spine resulting in compromise of a nerve root(s)

(see 1.00F), documented by A, B, C, and D:

A. Symptom(s) of neuro-anatomic (radicular) distribution of one or more of the following manifestations consistent with compromise of the affected nerve root(s):

1. Pain; or

2. Paresthesias; or

3. Muscle fatigue.

AND

B. Radicular neurological signs present during physical examination or testing and evidenced by 1, 2, and 4; or 1, 3, and 4 below:

1. Muscle weakness; and

2. Sensory changes evidenced by:

a. Decreased sensation; or

b. Sensory nerve deficit (abnormal sensory nerve latency) on electrodiagnostic testing; or

3. Decreased deep tendon reflexes; and

4. Sign(s) of nerve root irritation, tension, or compression, consistent with compromise of the affected nerve root (see 1.00F2).

AND

C. Findings on imaging consistent with compromise of a nerve root(s) in the cervical or lumbosacral spine (see 1.00C3).

AND

D. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months, and medical documentation of at least one of the following (see 1.00E):

1. A documented medical need for a walker, bilateral canes, or bilateral crutches;

or

2. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements, and a documented medical need for a one-handed assistive device that requires the use of the other upper extremity; or

3. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements.

1.16 Lumbar spinal stenosis resulting in compromise of the cauda equina (see 1.00G), documented by A, B, C, and D:

A. Symptoms of neurological compromise, such as pain, manifested as:

1. Nonradicular distribution of pain in one or both lower extremities; or
2. Nonradicular distribution of sensory loss in one or both extremities; or
3. Neurogenic claudication.

AND

B. Nonradicular neurological signs present during physical examination or testing and evidenced by 1 and 2, or 1 and 3, below:

1. Muscle weakness; and
2. Sensory changes evidenced by:
 - a. Decreased sensation; or

b. Sensory nerve deficit (abnormal sensory nerve latency) on electrodiagnostic testing; or

c. Areflexia, trophic ulceration, or bladder or bowel incontinence.

3. Decreased deep tendon reflexes in one or both lower extremities.

AND

C. Findings on imaging or in an operative report consistent with compromise of the cauda equina with lumbar spinal stenosis.

AND

D. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months, and medical documentation of at least one of the following (see 1.00E):

1. A documented medical need for a walker, bilateral canes, or bilateral crutches;

or

2. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements, and a documented

medical need for a one-handed assistive device that requires the use of the other upper extremity.

1.17 Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint (see 1.00H), documented by A, B, and C:

A. Documented history of reconstructive surgery or surgical arthrodesis of a major weight-bearing joint.

AND

B. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months.

AND

C. A documented medical need for a walker, bilateral canes, or bilateral crutches (see 1.00E).

1.18 Abnormality of a major joint(s) in any extremity (see 1.00I), documented by A, B, C, and D:

A. Chronic joint pain or stiffness.

AND

B. Abnormal motion, instability, or immobility of the affected joint(s).

AND

C. Anatomical abnormality of the affected joint(s) noted on:

1. Physical examination (for example, subluxation, contracture, bony or fibrous ankylosis); or

2. Imaging (for example, joint space narrowing, bony destruction, or ankylosis or arthrodesis of the affected joint).

AND

D. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months, and medical documentation of at least one of the following (see 1.00E):

1. A documented medical need for a walker, bilateral canes, or bilateral crutches;

or

2. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements, and a documented medical need for a one-handed assistive device that requires the use of the other upper extremity; or

3. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements.

1.19 Pathologic fractures due to any cause (see 1.00J), documented by A and B:

A. Three or more medically documented pathologic fractures occurring on separate occasions within a 12-month period;

AND

B. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months, and medical documentation of at least one of the following (see 1.00E):

1. A documented medical need for a walker, bilateral canes, or bilateral crutches;

or

2. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements, and a documented medical need for a one-handed assistive device that requires the use of the other upper extremity; or

3. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements.

1.20 Amputation due to any cause (see 1.00K), documented by A, B, C, or D:

A. Amputation of both upper extremities, occurring at any level above the wrists (carpal joints), up to and including the shoulder (glenohumeral) joint.

OR

B. Hemipelvectomy or hip disarticulation.

OR

C. Amputation of one upper extremity, occurring at any level above the wrist (carpal joints), and one lower extremity at or above the ankle (tarsal joint), and medical documentation of one the following (see 1.00E):

1. The documented medical need for a one-handed assistive device requiring the use of the other upper extremity; or

2. The inability to use the remaining upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements.

OR

D. Amputation of one or both lower extremities at or above the ankle (tarsal joint), with complications of the residual limb that have lasted or can be expected to last for at least 12 months, and medical documentation of both 1 and 2 (see 1.00E):

1. The inability to use a prosthetic device(s); and

2. The documented medical need for a walker, bilateral canes, or bilateral crutches.

1.21 Soft tissue injury or abnormality under continuing surgical management (see 1.00L), documented by A, B, and C in the medical record:

A. Evidence confirms ongoing surgical management directed towards saving, reconstructing, or replacing the affected part of the body.

AND

B. The surgical management has been, or is expected to be, ongoing for at least 12 months.

AND

C. Maximum benefit from therapy has not yet been achieved.

1.22 Non-healing or complex fracture of the femur, tibia, pelvis, or one or more of the tarsal bones (see 1.00M), documented by A and B and C:

A. Solid union not evident on appropriate medically acceptable imaging and not clinically solid;

AND

B. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months,

AND

C. Medical documentation of medical need for a walker, bilateral canes, or bilateral crutches (see 1.00E).

1.23 Non-healing or complex fracture of an upper extremity (see 1.00N), documented by A and B and C:

A. Nonunion of a fracture, or complex fracture of the shaft of the humerus, radius, or ulna, under continuing surgical management, as defined in 1.00O, directed toward restoration of functional use of the extremity;

AND

B. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months;

AND

C. Medical documentation of at least one of the following (see 1.00E):

1. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements, and a documented medical need for a one-handed assistive device that requires the use of the other upper extremity; or

2. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements.

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4.00 CARDIOVASCULAR SYSTEM

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G. Evaluating Peripheral Vascular Disease

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4. What is lymphedema and how will we evaluate it?

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b. * * * We will evaluate lymphedema by considering whether the underlying cause meets or medically equals any listing or whether the lymphedema medically equals a cardiovascular listing, such as 4.11 Chronic venous insufficiency, or a musculoskeletal listing, such as 1.18 Abnormality of a major joint(s) in any extremity. * * *

* * * * *

14.00 IMMUNE SYSTEM DISORDERS

* * * * *

C. Definitions

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2. Assistive device(s) has the same meaning as in 1.00C6a.

5. Documented medical need has the same meaning as in 1.00C6a.

8. Fine and gross movements has the same meaning as in 1.00E3.

9. Hand-held assistive device has the same meaning as in 1.00C6d.

10. Major joint of an upper or lower extremity has the same meaning as in 1.00I1.

* * * * *

D. How do we document and evaluate the listed autoimmune disorders?

* * * * *

4. Polymyositis and dermatomyositis (14.05).

* * * * *

c. ***

(i) Weakness of your pelvic girdle muscles that results in your inability to rise independently from a squatting or sitting position or to climb stairs may be an indication that you are unable to walk without physical or mechanical assistance. * * *

* * * * *

d. ***

6. ***

a. General. * * * Clinically, inflammation of major joints in an upper or lower extremity may be the dominant manifestation causing difficulties with walking or performing fine and gross movements; there may be joint pain, swelling, and tenderness. The arthritis may affect other joints, or cause less limitation in walking or performing fine and gross movements. * * *

* * * * *

e. ***

(i) Listing-level severity in 14.09 Inflammatory arthritis is shown by the presence of an impairment-related, significant limitation cited in the criteria of these listings. In 14.09A, listing-level severity is satisfied with persistent inflammation or deformity in one major joint in a lower extremity resulting in a documented medical need for a walker, bilateral canes, or bilateral crutches as required in 14.09A1, or one major joint in each upper extremity resulting in an impairment-related, significant limitation in the ability to perform fine and gross movements as required in 14.09A2. In 14.09C1, if you have the required ankylosis (fixation) of your cervical or dorsolumbar spine, we will find that you have an impairment-related significant limitation in your ability to see in front of you, above you, and to the side. Therefore, a listing-level impairment in the ability to walk is implicit in 14.09C1, even though you might not require bilateral upper limb assistance.

(ii) Listing-level severity is shown in 14.09B, 14.09C2, and 14.09D by inflammatory arthritis that involves various combinations of complications of one or more major joints in an upper or lower extremity or other joints, such as inflammation or deformity, extra-articular features, repeated manifestations, and constitutional symptoms or signs. * * *

* * * * *

14.04 Systemic sclerosis (scleroderma). As described in 14.00D3. With:

* * * * *

B. One of the following:

1. Toe contractures or fixed deformity of one or both feet, resulting in one of the following:

a. A documented medical need for a walker, bilateral canes, or bilateral crutches (see 14.00C9); or

b. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements, and a documented

medical need for a one-handed assistive device (see 14.00C9) that requires the use of the other upper extremity; or

2. Finger contractures or fixed deformity in both hands, resulting in an inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements; or

3. Atrophy with irreversible damage in one or both lower extremities, resulting in one of the following:

a. A documented medical need for a walker, bilateral canes, or bilateral crutches (see 14.00C9); or

b. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements, and a documented medical need for a one-handed assistive device (see 14.00C9) that requires the use of the other upper extremity; or

4. Atrophy with irreversible damage in both upper extremities, resulting in an inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements.

OR

C. Raynaud's phenomenon, characterized by:

* * * * *

2. Ischemia with ulcerations of toes or fingers, resulting in one of the following:

a. A documented medical need for a walker, bilateral canes, or bilateral crutches (see 14.00C9); or

b. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements, and a documented medical need for a one-handed assistive device (see 14.00C9) that requires the use of the other upper extremity; or

c. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements.

* * * * *

14.05 Polymyositis and dermatomyositis. As described in 14.00D4. With:

A. Proximal limb-girdle (pelvic or shoulder) muscle weakness, resulting in one of the following:

1. A documented medical need for a walker, bilateral canes, or bilateral crutches (see 14.00C9); or

2. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements, and a documented medical need for a one-handed assistive device (see 14.00C9) that requires the use of the other upper extremity; or

3. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements.

* * * * *

14.09 Inflammatory arthritis. As described in 14.00D6. With:

A. Persistent inflammation or persistent deformity of:

1. One or more major joints in a lower extremity(ies) resulting in one of the following:

a. A documented medical need for a walker, bilateral canes, or bilateral crutches (see 14.00C9); or

b. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements, and a documented medical need for a one-handed assistive device (see 14.00C9) that requires the use of the other upper extremity; or

2. One or more major joints in each upper extremity resulting in an inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements.

OR

B. Inflammation or deformity in one or more major joints of an upper or lower extremity(ies) with: * * *

* * * * *

Part B

* * * * *

101.00 Musculoskeletal Disorders.

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101.00 MUSCULOSKELETAL DISORDERS

A. Which disorders do we evaluate under these listings?

1. We evaluate disorders of the skeletal spine (vertebral column) or of the upper or lower extremities that affect musculoskeletal functioning in the musculoskeletal body system listings. We use the term “skeletal” when we are referring to the structure of the bony skeleton. The skeletal spine refers to the bony structures, ligaments, and discs making up the spine. We refer to the “skeletal” spine in some musculoskeletal listings to differentiate it from the neurological spine (see 101.00B1). Disorders may be congenital or acquired, and may include deformities, amputations, or other musculoskeletal abnormalities. These disorders may involve the bones or major joints; or the tendons, ligaments, muscles, or other soft tissues.

2. We also evaluate soft tissue abnormalities or injuries (including burns) that are under continuing surgical management (see 101.00L). The abnormalities or injuries may affect any part of the body, including the face and skull.

B. Which related disorders do we evaluate under other listings?

1. We evaluate a disorder or injury of the skeletal spine that results in damage to, and neurological dysfunction of, the spinal cord and its associated nerves (for example, paraplegia or quadriplegia) under the criteria in 111.00 Neurological Disorders.

2. We evaluate inflammatory arthritis (for example, rheumatoid arthritis) under the criteria in 114.00 Immune System Disorders.

3. We evaluate curvatures of the skeletal spine under these musculoskeletal disorders listings and other listings as appropriate for the affected body system. Curvatures of the skeletal spine that affect musculoskeletal functioning are evaluated under 101.15 Disorders of the skeletal spine resulting in compromise of a nerve root(s). If a curvature of the skeletal spine is under continuing surgical management, we can evaluate it for medical equivalence to 101.21 Soft tissue injury or abnormality under continuing surgical management. Skeletal curvatures may also adversely affect functioning in body systems other than the musculoskeletal system. For example, the curvature may interfere with your ability to breathe (see 103.00 Respiratory Disorders); there may be impaired myocardial function (see 104.00 Cardiovascular System); or there may be disfigurement resulting in social withdrawal or depression (see 112.00 Mental Disorders).

4. We evaluate non-healing or pathological fractures due to cancer, whether it is a primary site or metastases, under the criteria in 113.00 Cancer (Malignant Neoplastic Diseases).

5. We evaluate the leg pain associated with peripheral vascular claudication under the criteria in 104.00 Cardiovascular System.

6. We evaluate burns that do not require continuing surgical management under the criteria in 108.00 Skin Disorders.

C. What evidence do we need to evaluate your musculoskeletal disorder under these listings?

1. General. To establish the presence of a musculoskeletal disorder as a medically determinable impairment, we need objective medical evidence from an acceptable medical source who has examined you for the disorder. To assess the severity and duration of your disorder, we evaluate evidence from both medical and nonmedical sources who can describe how you function. If there is no record of ongoing medical treatment for your disorder, we will follow the guidelines in 101.00Q How do we evaluate the severity and duration of your established musculoskeletal disorder when there is no record of ongoing treatment? We will determine the extent and kinds of evidence we need from medical and non-medical sources based on the individual facts about your disorder. For our basic rules on evidence, see §§ 416.902, 416.912, 416.913,

416.913a, and 416.920b of this chapter. For our rules on evidence about your symptoms, see § 416.929 of this chapter.

2. Physical examination report(s). In the report(s) of your physical examination, we need a detailed description of the orthopedic, neurologic, or other objective clinical findings appropriate to your specific musculoskeletal disorder. We require objective clinical findings from the medical source's direct observations during your physical examination, not simply his or her report of your statements about your symptoms and limitations. When the medical source reports that a clinical test sign(s) is positive, unless we have evidence to the contrary, we will assume that he or she performed the test properly. For instance, we will assume a straight-leg raising test was conducted properly, i.e., in a sitting and supine position, even if the medical source does not specify the positions in which the test was performed. In the absence of evidence to the contrary, we will accept the medical source's interpretation of the test. If you use an assistive device (see 101.00C6), the report must support the medical need for the device. If reduction in muscle strength is a factor, we require medical documentation of measurement of the strength of the muscle(s) in question, generally based on a grading system of 0 to 5. Zero (0) indicates complete loss of strength and 5 indicates maximum strength, consistent with Table 1 below. The documentation should also include measurements of grip and pinch strength, if there is evidence of involvement of one or both hands.

Table 1

Grading Scale of Muscle Function: 0 to 5		
0	None	No visible or palpable contraction

1	Trace	Visible or palpable contraction with no motion
2	Poor	Active range of motion (ROM) with gravity eliminated
3	Fair	Active ROM against gravity only, without resistance
4	Good	Active ROM against gravity, moderate resistance
5	Normal	Active ROM against gravity, maximum resistance

3. Laboratory findings: Imaging and other diagnostic tests

a. Imaging refers to medical imaging techniques, such as x-ray, computed tomography (CT), magnetic resonance imaging (MRI), and radionuclide scanning. For the purpose of these listings, the imaging technique(s) must be consistent with the generally accepted standards of medical knowledge and clinical practice.

b. Findings on imaging must have lasted, or must be expected to last, for a continuous period of at least 12 months.

c. Imaging and other diagnostic tests can provide evidence of physical abnormalities; however, they may correlate poorly with your symptoms, including pain, or with your musculoskeletal functioning. Accordingly, we cannot use such tests as a substitute for physical examination findings about your ability to function, nor can we infer severity or functional limitations based solely on such tests.

d. For our policies about when we will purchase imaging and other diagnostic tests, see §§ 416.919k and 416.919m of this chapter.

4. Operative reports. If you have had a surgical procedure(s), we need either the operative reports, including details of the findings at surgery and information about any medical complications that may have occurred, or confirmatory evidence of the surgical procedure(s) from a medical source (for example, detailed follow-up reports or notations in the medical records concerning your past medical history).

5. Effects of treatment

a. General. Treatments for musculoskeletal disorders may have beneficial or adverse effects, and responses to treatment vary from person to person. We will evaluate all of the effects of treatment (including surgical treatment, medications, and therapy) on the symptoms, signs, and laboratory findings of your musculoskeletal disorder, and on your musculoskeletal functioning.

b. Response to treatment. To evaluate your musculoskeletal functioning in response to treatment, we need specific information related to your impairment, including the following: a description of your medications, including frequency of administration; the type and frequency of therapy you receive; and a description of your response to treatment and any complications you experience related to your impairment. The effects of treatment may be temporary or long-term. We need information over a sufficient period to determine the effect of treatment on your current musculoskeletal functioning and to permit reasonable projections about your future functioning. In some cases, we

will need additional evidence to make an assessment about your response to treatment. Depending upon the timing of this treatment in relation to the alleged onset date of disability, we may need to defer evaluation of the impairment for a period of up to 3 months from the date treatment began to permit consideration of treatment effects, unless we can make a determination or decision using the evidence we have.

6. Assistive devices

a. General. An assistive device, for the purposes of these listings, is any device that is used to improve stability, dexterity, or mobility. An assistive device can be worn (see 101.00C6b and c), or hand-held (see 101.00C6d). If you use any type of assistive device(s), we need evidence from a medical source regarding the documented medical need for the device(s). When we use the term “documented medical need,” we mean that there is evidence from a medical source(s) in the medical record that supports your need for an assistive device (see § 416.913 of this chapter). The evidence must include documentation from a medical source(s) describing any limitation(s) in your upper or lower extremity functioning that supports your need for the assistive device, and supporting the circumstances for which you need it. The evidence does not have to include a specific prescription for the device.

b. Prosthesis(es). A prosthesis is a wearable device, such as an artificial limb, that takes the place of an absent body part. We need evidence from a medical source documenting your ability to walk, or to perform fine and gross movements (see

101.00E4), with the prosthesis(es) in place. When amputation(s) involves a lower extremity or extremities, it is not necessary to evaluate your ability to walk without the prosthesis(es) in place. If you cannot use your prosthesis(es) due to complications affecting your residual limb(s), we need documentation from a medical source regarding the condition of your residual limb(s) and the medical basis for your inability to use the prosthesis(es).

c. Orthosis(es). An orthosis is a wearable device that prevents or corrects a dysfunction or deformity by aligning or supporting the affected body part. An orthosis may also be referred to as a “brace.” If you have an orthosis(es), we need evidence from a medical source documenting your ability to walk, or to perform fine and gross movements, with the orthosis(es) in place. If you cannot use your orthosis(es), we need evidence from a medical source documenting the medical basis for your inability to use the device(s).

d. Hand-held assistive devices. Hand-held assistive devices include canes, crutches, or walkers, and are carried in your hand(s) to support or aid you in walking. When you require a one-handed assistive device for ambulation, such as a cane or single crutch, and your other upper extremity has limitations preventing its use for fine or gross movement(s) (see 101.00E4), the need for the assistive device limits the use of both upper extremities. If you use a hand-held assistive device, we need evidence from a medical source documenting your need for the device(s) and describing how you walk with the device(s).

7. Longitudinal evidence

a. We generally need a longitudinal medical record to assess the duration of your musculoskeletal disorder, because symptoms, signs, and laboratory findings related to most musculoskeletal disorders may wax and wane, may improve over time, or may respond to treatment. By providing evidence over an extended period, the medical record will show whether your musculoskeletal functioning is improving, worsening, or unchanging.

b. For 101.19 Pathologic fractures due to any cause and 101.21 Soft tissue injury or abnormality under continuing surgical management, the required 12-month duration period is stated in the listing itself. For 101.20A (amputation of both upper extremities) or 101.20B (hemipelvectomy or hip disarticulation), we presume satisfaction of the duration requirement.

c. For all listings not referenced in 101.00C7b above, all of the required criteria must be present simultaneously, or within a close proximity of time, to satisfy the level of severity needed to meet the listing. When we use the term “close proximity of time,” we mean that all of the relevant criteria have to appear in the medical record within a period not to exceed 4 months of one another. When the criterion in question is imaging, we mean those findings on imaging that we could reasonably expect to have been present at the date of impairment or date of onset. To meet a listing that uses the word “and” or

“AND” to link the elements of the required criteria, the medical record must establish the simultaneous presence, or presence within a close proximity of time, of all the required medical criteria. Once this level of severity is established, the medical record must also show that this level of severity has continued, or is expected to continue, for a continuous period of at least 12 months.

8. Surgical treatment

For some musculoskeletal disorders, a medical source may recommend surgery. If you have not yet had the recommended surgery, we will not deny your claim based on an assumption that surgery will resolve or improve your disorder. We will assess each case on an individual basis. Depending on your response to treatment, or depending on your medical sources' treatment plans, we may defer our findings regarding the effect of surgical intervention until a sufficient period has passed to permit proper consideration or judgment about your future functioning. See 101.00C5b Response to treatment.

D. How do we consider symptoms, including pain, under these listings?

1. Individuals with musculoskeletal disorders may experience pain or other symptoms; however, statements alone about your pain or other symptoms cannot establish that you are disabled. Further, an alleged or reported increase in the intensity of a symptom, such as pain, no matter how severe, cannot be substituted for a medical sign or diagnostic finding present in the listing criteria. Pain is included as just one

consideration in paragraph A in listings 101.15, 101.16, and 101.18, but is not required to satisfy the criteria in these listings. Examples of other findings that will satisfy the criteria in paragraph A include muscle fatigue, nonradicular distribution of sensory loss in one or both extremities, and joint stiffness.

2. To consider your pain, we require objective medical evidence from an acceptable medical source showing the existence of a medically determinable impairment(s) (MDI) that could reasonably be expected to produce the pain. When your musculoskeletal MDI could reasonably be expected to produce the pain or other symptoms alleged, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with all of the objective medical evidence, including medical signs and laboratory or diagnostic findings. See § 416.929 of this chapter for information on how we evaluate pain or other symptoms related to a musculoskeletal impairment.

E. How do we use the functional criteria under these listings?

1. General. We will determine that your musculoskeletal disorder meets a listing if it satisfies the medical criteria; includes at least one of the functional criteria, if included in the listing; and satisfies the 12-month duration requirement. We will use the relevant evidence that we have to compare your musculoskeletal functioning to the functioning of children your age who do not have impairments. For example, if you are able to walk at home without an assistive device, we will not consider that to be

conclusive evidence that you have similar functioning to other children your age who do not have impairments.

2. Medical and functional criteria, birth to attainment of age 3. The medical and functional criteria for children in this age group are in 101.24 Musculoskeletal disorders of infants and toddlers, from birth to attainment of age 3, with developmental motor delay.

3. Functional criteria, age 3 to attainment of age 18. The functional criteria are based on impairment-related physical limitations in your ability to use both upper extremities, one or both lower extremities, or a combination of one upper and one lower extremity. A musculoskeletal disorder satisfies the functional criteria of a listing when the medical documentation shows the presence of at least one of the impairment-related limitations cited in the listing. The functional criteria require impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months, medically documented by one of the following:

a. A documented medical need (see 101.00C6a) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d);

b. An inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 101.00E4),

and a documented medical need (see 101.00C6a) for a one-handed assistive device (see 101.00C6d) that requires the use of your other upper extremity;

c. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 101.00E4).

4. Fine and gross movements. Fine movements, for the purposes of these listings, involve use of your wrists, hands, and fingers; such movements include picking, pinching, manipulating, and fingering. Gross movements involve use of your shoulders, upper arms, forearms, and hands; such movements include handling, gripping, grasping, holding, turning, and reaching. Gross movements also include exertional abilities such as lifting, carrying, pushing, and pulling.

5. When we do not use the functional criteria. We do not use the functional criteria to evaluate amputation of both upper extremities under 101.20A, hemipelvectomy or hip disarticulation under 101.20B, and soft tissue injuries or abnormalities under continuing surgical management under 101.21.

F. What do we consider when we evaluate disorders of the skeletal spine resulting in compromise of a nerve root(s) (101.15)?

1. General. We consider musculoskeletal disorders such as skeletal dysplasias, caudal regression syndrome, tethered spinal cord syndrome, vertebral slippage (spondylolisthesis), scoliosis, and vertebral fracture or dislocation. Spinal disorders may cause cervical or lumbar spine dysfunction when abnormalities of the skeletal spine compromise nerve roots of the cervical spine, a nerve root of the lumbar spine, or a nerve root of both cervical and lumbar spines.

2. Compromise of a nerve root(s). Compromise of a nerve root(s), sometimes referred to as “nerve root impingement,” is a term used when a physical object is seen pushing on the nerve root in an imaging study or during surgery. Objects such as tumors, herniated discs, foreign bodies, or arthritic spurs may cause compromise of a nerve root. It can occur when a musculoskeletal disorder produces irritation, inflammation, or compression of the nerve root(s) as it exits the skeletal spine between the vertebrae. Related symptoms must be associated with, or follow the path of, the specific nerve root(s), thereby presenting a neuro-anatomic (usually referred to as “radicular”) distribution of symptoms and signs, including pain, paresthesia (for example, burning, prickling, or tingling), sensory loss, and usually muscle weakness specific to the affected nerve root(s).

a. Compromise of unilateral nerve root of the cervical spine. Compromise of a nerve root as it exits the cervical spine between the vertebrae may affect the functioning of the associated upper extremity. The clinical examination reproduces the related

symptoms based on radicular signs and clinical tests (for example, a positive Spurling's Test) appropriate to the specific cervical nerve root.

b. Compromise of bilateral nerve roots of the cervical spine. Although uncommon, if compromise of a nerve root occurs on both sides of the cervical spinal column, functioning of both upper extremities may be limited.

c. Compromise of a nerve root(s) of the lumbar spine. Compromise of a nerve root as it exits the lumbar spine between the vertebrae may limit the functioning of the associated lower extremity. The clinical examination reproduces the related symptoms based on radicular signs and clinical tests. When a nerve root of the lumbar spine is compromised, we require a positive straight-leg raising test (also known as a Lasegue test) in both supine and sitting positions appropriate to the specific lumbar nerve root that is compromised. (See 101.00C2 for guidance on interpreting information from a physical examination report.)

G. What do we consider when we evaluate lumbar spinal stenosis resulting in compromise of the cauda equina (101.16)?

1. We consider the limiting effects of pain, sensory changes, and muscle weakness caused by compromise of the cauda equina due to lumbar spinal stenosis. The cauda equina is a bundle of nerve roots that descends from the lower part of the spinal cord. Lumbar spinal stenosis can compress the nerves of the cauda equina, causing

sensory changes and muscle weakness that may affect your ability to stand or walk. Pain related to compromise of the cauda equina is “nonradicular,” because it is not typically associated with a specific nerve root (as is radicular pain in the cervical or lumbar spine).

2. Compromise of the cauda equina due to spinal stenosis can affect your ability to walk because of neurogenic claudication (also known as pseudoclaudication), a disorder usually causing non-radicular pain that starts in the low back and radiates bilaterally (or less commonly, unilaterally) into the buttocks and lower extremities (or extremity). Extension of the lumbar spine, as when walking or merely standing, provokes the pain of neurogenic claudication. It is relieved by forward flexion of the lumbar spine or by sitting.

H. What do we consider when we evaluate reconstructive surgery or surgical arthrodesis of a major weight-bearing joint (101.17)?

1. We consider reconstructive surgery or surgical arthrodesis when an acceptable medical source(s) documents the surgical procedure(s) and associated medical treatments to restore function of the affected body part(s). The reconstructive surgery may be a single event or it may be a series of procedures directed toward the salvage or restoration of functional use of the affected joint.

2. Major weight-bearing joints. The major weight-bearing joints are the hip, knee, and ankle-foot. The ankle and foot are considered together as one major joint.

3. Surgical arthrodesis. Surgical arthrodesis is the artificial fusion of the bones that form a joint, essentially eliminating the joint.

I. What do we consider when we evaluate abnormality of a major joint(s) in any extremity (101.18)?

1. General. We consider musculoskeletal disorders that produce anatomical abnormalities of major joints of the extremities, resulting in functional abnormalities in the upper or lower extremities (for example, infections of bones and joints). Major joint of an upper extremity refers to the shoulder, elbow, and wrist-hand. We consider the wrist and hand together as one major joint. Major joint of a lower extremity refers to the hip, knee, and ankle-foot. We consider the ankle and hindfoot together as one major joint, because it is necessary for walking. Abnormalities affecting the joints may include ligamentous laxity or rupture, soft tissue contracture, or tendon rupture, and can cause muscle weakness of the affected body part.

2. How do we define abnormality in the extremities? An anatomical abnormality in any extremity(ies) is one that is readily observable by a medical source during a physical examination (for example, subluxation or contracture), or is present on imaging (for example, ankylosis, bony destruction, joint space narrowing, or deformity). A functional abnormality is abnormal motion or instability of the affected part(s), including limitation of motion, excessive motion (hypermobility), movement outside the normal

plane of motion for the joint (for example, lateral deviation), or fixation of the affected parts.

J. What do we consider when we evaluate pathologic fractures due to any cause (101.19)? We consider pathologic fractures of the bones in the skeletal spine, extremities, or other parts of the skeletal system. Pathologic fractures result from disorders that weaken the bones, making them vulnerable to breakage. For non-healing or complex traumatic fractures without accompanying pathology, see 101.22 Non-healing or complex fracture of the femur, tibia, pelvis, or one or more of the tarsal bones, or 101.23 Non-healing fracture of an upper extremity. Pathologic fractures may occur with osteoporosis, osteogenesis imperfecta or any other skeletal dysplasias, side effects of medications, and disorders of the endocrine or other body systems. They must occur on separate, distinct occasions, rather than multiple fractures occurring at the same time, but they may affect the same bone(s) multiple times. There is no required period between the incidents of fracture(s), but they must all occur within a 12-month period; for example, separate incidents may occur within hours or days of each other. However, the associated limitation(s) of function must last, or be expected to last, at least 12 months.

K. What do we consider when we evaluate amputation due to any cause (101.20)?

1. General. We consider amputations (the full or partial loss or absence of any extremity) due to any cause, including trauma, congenital abnormality or absence, or surgery for treatment of conditions such as cancer or infection.

2. Amputation of both upper extremities (101.20A). Upper extremity amputations, for the purposes of this listing, may occur at any level above the wrists (carpal joints), up to and including disarticulation of the shoulder (glenohumeral) joint. We do not evaluate amputations below the wrists under this listing, because the resulting limitation of function of the thumb(s), finger(s), or hand(s) will vary, depending on the extent of loss and corresponding effect on fine and gross movements (see 101.00E4). For amputations below the wrist, we will follow our rules for determining functional equivalence to the listings (see § 416.926a of this chapter).

3. Hemipelvectomy or hip disarticulation (101.20B). Hemipelvectomy involves amputation of an entire lower extremity through the sacroiliac joint. Hip disarticulation involves amputation of an entire lower extremity through the hip joint capsule and closure of the remaining musculature over the exposed acetabular bone.

4. Amputation of one upper extremity at any level above the wrist and one lower extremity at or above the ankle (101.20C). We evaluate the absence of one upper extremity and one lower extremity with regard to whether you have a documented medical need (see 101.00C6a) for a one-handed assistive device (see 101.00C6d), such as a cane or crutch. In this situation, you may wear a prosthesis (see 101.00C6b) on your lower extremity, but nevertheless have a documented medical need for a one-handed assistive device. If you do, you would need to use your other upper extremity to hold the assistive device, making the extremity unavailable to perform other fine and gross

movements (see 101.00E4) such as carrying. In such a case, your disorder would meet this listing.

5. Amputation of one or both lower extremities at or above the ankle (tarsal joint), (101.20D). When we evaluate amputations of one or both lower extremities:

a. We consider the condition of your residual limb(s), and whether you can wear a prosthesis(es) (see 101.00C6b). When you have a prosthesis(es), we will examine your residual limb with the prosthesis(es) in place. If you are unable to use a prosthesis(es) because of residual limb complications that have lasted, or are expected to last, for at least 12 months, and you are not currently undergoing surgical management (see 101.00L1) of your condition, we evaluate your disorder under this listing.

b. Under 101.20D “Amputation of one or both lower extremities at or above the ankle (tarsal joint),” we consider whether you have a documented medical need (see 101.00C6a) for a hand-held assistive device(s) (see 101.00C6d) and your ability to walk with the device(s).

c. If you have a non-healing residual limb(s) and are receiving ongoing surgical treatment expected to re-establish or improve function, and that ongoing surgical treatment has not ended, or is not expected to end, within at least 12 months of the initiation of the surgical management (see 101.00L1), we evaluate your disorder under 101.21 Soft tissue injury or abnormality under continuing surgical management.

L. What do we consider when we evaluate soft tissue injury or abnormality under continuing surgical management (101.21)?

1. General.

a. We consider any soft tissue injury or abnormality involving the soft tissues of the body, whether congenital or acquired, when an acceptable medical source(s) documents the need for ongoing surgical procedures and associated medical treatments to restore function of the affected body parts. Surgical management includes the surgery(-ies) itself, as well as various post-surgical procedures, surgical complications, infections or other medical complications, related illnesses, or related treatments that delay a person's attainment of maximum benefit from therapy.

b. Surgical procedures and associated treatments typically take place over extended periods, which may render you unable to perform age-appropriate activity on a sustained basis. To document such inability, we must have evidence from an acceptable medical source(s) confirming that the surgical management has continued, or is expected to continue, for at least 12 months from the date of the first surgical intervention. These procedures and treatments must be directed toward saving, reconstructing, or replacing the affected part of the body to re-establish or improve its function, and not for cosmetic appearances alone.

c. Examples include malformations, third- and fourth-degree burns, crush injuries, craniofacial injuries, avulsive injuries, and amputations with complications of the residual limb(s).

d. We evaluate skeletal spine abnormalities or injuries under 101.15 Disorders of the skeletal spine resulting in compromise of a nerve root(s) or 101.16 Lumbar spinal stenosis resulting in compromise of the cauda equina, as appropriate. We evaluate abnormalities or injuries of bones in the lower extremities under 101.17 Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint, 101.18 Abnormality of a major joint(s) in any extremity, or 101.22 Non-healing fracture of the femur, tibia, pelvis, or one or more of the tarsal bones. We evaluate abnormalities or injuries of bones in the upper extremities under 101.18 Abnormality of a major joint(s) in any extremity, or 101.23 Non-healing or complex fracture of an upper extremity.

2. Documentation. In addition to the objective medical evidence we need to establish your soft tissue injury or abnormality, we also need all of the following medically documented evidence about your continuing surgical management:

- a. Operative reports and related laboratory findings;
- b. Records of post-surgical procedures;

c. Records of any surgical or medical complications (for example, related infections or systemic illnesses);

d. Records of any prolonged post-operative recovery periods and related treatments (for example, surgeries and treatments for burns); and

e. An acceptable medical source's plans for additional surgeries;

f. Records detailing any other factors that have delayed, or that an acceptable medical source expects to delay, the saving, restoring, or replacing of the involved part for a continuous period of at least 12 months following the initiation of the surgical management.

3. Burns. Third- and fourth-degree burns damage or destroy nerve tissue, reducing or preventing transmission of signals through those nerves. Such burns frequently require multiple surgical procedures and related therapies to re-establish or improve function, which we evaluate under 101.21 Soft tissue injury or abnormality under continuing surgical management. When burns are no longer under continuing surgical management, we evaluate the residual impairment(s) (see 101.00P). When the residual impairment(s) affects the musculoskeletal system, as often occurs in third and fourth degree burns, it can result in permanent musculoskeletal tissue loss, joint contractures, or loss of extremities. We will evaluate such impairments under the relevant musculoskeletal listing(s), for example, 101.18 Abnormality of a major joint(s) in any extremity or 101.20 Amputation

due to any cause. When the residual impairment(s) involves another body system(s), we will evaluate the impairment(s) under the relevant body system listing (for example, 108.08 Burns).

4. Congenital abnormalities or craniofacial injuries. Surgeons may treat craniofacial injuries or abnormalities with multiple surgical procedures. These injuries or abnormalities may affect vision, hearing, speech, and the initiation of the digestive process, including mastication. When the craniofacial injury-related or congenital residual impairment(s) involves another body system(s), we will evaluate the impairment(s) under the relevant body system listings. See 101.00P regarding evaluation of residual impairment(s).

M. What do we consider when we evaluate non-healing or complex fractures of the femur, tibia, pelvis, or one or more of the tarsal bones (101.22)?

1. We evaluate a non-healing (nonunion) or complex fracture of the femur, tibia, pelvis, or one or more of the tarsal bones with regard to whether you have a documented medical need (see 101.00C6a) for a bilateral (two-handed) assistive device (see 101.00C6d), such as a walker or bilateral crutches.

2. Non-healing fracture. A non-healing fracture is a fracture that has failed to unite completely. Nonunion is usually established when a minimum of 9 months has

elapsed since the injury and the fracture site has shown no progressive signs of healing for a minimum of 3 months.

3. Complex fracture. A fracture is complex when one or more of the following occur:

- a. Comminuted (broken into many pieces) bone fragments,
- b. Multiple fractures in a single bone,
- c. Bone loss due to severe trauma,
- d. Damage to the surrounding soft tissue,
- e. Severe cartilage damage to the associated joint, or
- f. Dislocation of the associated joint.

4. When a complex fracture involves soft tissue damage, the treatment may involve continuing surgical management to restore or improve functioning. In such cases, we may evaluate the fracture(s) under 101.21 Soft tissue injury or abnormality under continuing surgical management.

N. What do we consider when we evaluate non-healing or complex fractures of an upper extremity (101.23)?

1. We evaluate a non-healing (nonunion) or complex fracture of an upper extremity under continuing surgical management (see 101.00L1a) with regard to whether you have an inability to use both upper extremities to independently initiate, sustain, and complete fine and gross movements.

2. Non-healing fracture. A non-healing fracture is a fracture that has failed to unite completely. Nonunion is usually established when a minimum of 9 months has elapsed since the injury and the fracture site has shown no progressive signs of healing for a minimum of 3 months.

3. Complex fracture. A fracture is complex when one or more of the following occur:

- a. Comminuted (broken into many pieces) bone fragments
- b. Multiple fractures in a single bone
- c. Bone loss due to severe trauma
- d. Damage to the surrounding soft tissue

e. Severe cartilage damage to the associated joint

f. Dislocation of the associated joint.

O. What do we consider when we evaluate musculoskeletal disorders of infants and toddlers from birth to attainment of age 3 with developmental motor delay (101.24)?

1. Under listing 101.24 Musculoskeletal disorders of infants and toddlers, from birth to attainment of age 3, with developmental motor delay, we use reports from an acceptable medical source(s) to establish a diagnosis of delay in your motor development. To evaluate the severity level of your developmental motor delay, we accept developmental test reports from an acceptable medical source, or from early intervention specialists, physical and occupational therapists, and other sources.

a. If there is a standardized developmental assessment in your medical record, we will use the results to evaluate your developmental motor delay under 101.24A. Such an assessment compares your level of development to the level typically expected for children of your chronological age. If you were born prematurely, we use your corrected chronological age (CCA) for comparison. Your CCA is your chronological age adjusted by a period of gestational prematurity (CCA = (chronological age) – (number of weeks premature)) (see § 416.924b(b) of this chapter).

b. If there is no standardized developmental assessment in your medical record, we will use narrative developmental reports from a medical source(s) to evaluate your developmental motor delay under 101.24B. These reports must provide detailed information sufficient for us to assess the severity of your motor delay. If we cannot obtain sufficient detail from narrative reports, we may purchase standardized developmental assessments.

(i) A narrative developmental report is based on clinical observations, progress notes, and well-baby check-ups, and must include your developmental history; examination findings (with abnormal findings noted on repeated examinations); and an overall assessment of your development (that is, more than one or two isolated skills) by the medical source.

(ii) Some narrative developmental reports may include results from developmental screening tests, which can show that you are not developing or achieving skills within expected timeframes. Although medical sources may refer to screening test results as supporting evidence in the narrative developmental report, screening test results alone cannot establish a medically determinable impairment or the severity of developmental motor delay.

2. Examples of disorders we evaluate include arthrogryposis, clubfoot, osteogenesis imperfecta, caudal regression syndrome, fracture complications, disorders affecting the hip and pelvis, and complications associated with your disorder or its

treatment. Some medical records may simply document your condition as “developmental motor delay.”

P. How do we determine when your soft tissue injury or abnormality or your upper extremity fracture is no longer under continuing surgical management or you have received maximum therapeutic benefit?

1. Your soft tissue injury or abnormality or your upper extremity fracture is no longer under continuing surgical management when the last surgical procedure or medical treatment directed toward the re-establishment or improvement of function of the involved part has occurred. We will find that you have received maximum therapeutic benefit from treatment if there are no significant changes in physical findings or on appropriate imaging for any 6-month period after the last surgical procedure or medical treatment. We may also find that you have received maximum therapeutic benefit if your medical source(s) indicates that further improvement is not expected after the last surgical procedure or medical treatment.

2. When you have received maximum therapeutic benefit from treatment, we will evaluate any impairment-related residual symptoms, signs, and laboratory findings (including those on imaging), any complications associated with your surgical procedures or medical treatments, and any residual limitations in your functioning. Depending upon all of those factors, we may find that your musculoskeletal impairment is no longer severe.

3. If your impairment(s) remains severe, we will evaluate your residual limitations and all other impairment-related factors to determine whether your musculoskeletal disorder meets or medically equals another listing or functionally equals the listings. If your impairment involves burns and remains severe, we will follow the above sequence by evaluating your impairment as described in 101.00L3.

Q. How do we evaluate the severity and duration of your established musculoskeletal disorder when there is no record of ongoing treatment?

1. You may not have received ongoing treatment or may not have an ongoing relationship with the medical community despite having a musculoskeletal disorder(s). In either of these situations, you will not have a longitudinal medical record for us to review when we evaluate your disorder. We may therefore ask you to attend a consultative examination to determine the severity and potential duration of your disorder (see § 416.919a(b) of this chapter).

2. In some instances, we may be able to assess the severity and duration of your musculoskeletal disorder based on your medical record and current evidence alone. If the information in your case record is not sufficient or appropriate to show that you have a musculoskeletal disorder that meets the criteria of one of the musculoskeletal disorders listings, we will follow the rules in 101.00R.

R. How do we evaluate disorders that do not meet one of the musculoskeletal listings?

1. These listings are only examples of musculoskeletal disorders that we consider severe enough to result in marked and severe functional limitations. If your musculoskeletal disorder(s) does not meet the criteria of any of these listings, we will consider whether you have an impairment(s) that meets the criteria of a listing in another body system.

2. If you have a severe medically determinable impairment(s) that does not meet any listing, we will determine whether your impairment(s) medically equals a listing (see § 416.926 of this chapter). If it does not medically equal a listing, we will determine whether it functionally equals the listings (see § 416.926a of this chapter).

3. We use the rules in § 416.994a of this chapter when we decide whether you continue to be disabled.

101.01 Category of Impairments, Musculoskeletal Disorders

101.15 Disorders of the skeletal spine resulting in compromise of a nerve root(s)
(see 101.00F), documented by A, B, C, and D:

A. Symptom(s) of neuro-anatomic (radicular) distribution of one or more of the following manifestations consistent with compromise of the affected nerve root(s):

1. Pain; or
2. Paresthesias; or
3. Muscle fatigue.

AND

B. Radicular neurological signs present during physical examination or testing and evidenced by 1, 2, and 4; or 1, 3, and 4 below:

1. Muscle weakness; and
2. Sensory changes evidenced by:
 - a. Decreased sensation; or
 - b. Sensory nerve deficit (abnormal sensory nerve latency) on electrodiagnostic testing; or

3. Decreased deep tendon reflexes; and

4. Sign(s) of nerve root irritation, tension, or compression, consistent with compromise of the affected nerve root (see 101.00F2).

AND

C. Findings on imaging consistent with compromise of a nerve root(s) in the cervical or lumbosacral spine (see 101.00C3).

AND

D. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months, and medical documentation of at least one of the following (see 101.00E):

1. A documented medical need for a walker, bilateral canes, or bilateral crutches;

or

2. An inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements, and a documented medical need for a one-handed assistive device that requires the use of the other upper extremity; or

3. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements.

101.16 Lumbar spinal stenosis resulting in compromise of the cauda equina (see 101.00G), documented by A, B, C, and D:

A. Symptoms of neurological compromise, such as pain, manifested as:

1. Nonradicular distribution of pain in one or both lower extremities; or
2. Nonradicular distribution of sensory loss in one or both extremities; or
3. Neurogenic claudication.

AND

B. Nonradicular neurological signs present during physical examination or testing and evidenced by 1 and 2, or 1 and 3, below:

1. Muscle weakness; and

2. Sensory changes evidenced by:

a. Decreased sensation; or

b. Sensory nerve deficit (abnormal sensory nerve latency) on electrodiagnostic testing; or

c. Areflexia, trophic ulceration, or bladder or bowel incontinence.

3. Decreased deep tendon reflexes in one or both lower extremities.

AND

C. Findings on imaging or in an operative report consistent with compromise of the cauda equina with lumbar spinal stenosis.

AND

D. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months, and medical documentation of at least one of the following (see 101.00E):

1. A documented medical need for a walker, bilateral canes, or bilateral crutches;
or

2. An inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements, and a documented medical need for a one-handed assistive device that requires the use of the other upper extremity.

101.17 Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint (see 101.00H), documented by A and B and C:

A. Documented history of reconstructive surgery or surgical arthrodesis of a major weight-bearing joint.

AND

B. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months.

AND

C. A documented medical need for a walker, bilateral canes, or bilateral crutches (see 101.00E).

101.18 Abnormality of a major joint(s) in any extremity (see 101.00I),
documented by A, B, C, and D:

A. Chronic joint pain or stiffness.

AND

B. Abnormal motion, instability, or immobility of the affected joint(s).

AND

C. Anatomical abnormality of the affected joint(s) noted on:

1. Physical examination (for example, subluxation, contracture, bony or fibrous ankylosis); or

2. Imaging (for example, joint space narrowing, bony destruction, or ankylosis or arthrodesis of the affected joint).

AND

D. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months, and medical documentation of at least one of the following (see 101.00E):

1. A documented medical need for a walker, bilateral canes, or bilateral crutches;
or

2. An inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements, and a documented medical need for a one-handed assistive device that requires the use of the other upper extremity; or

3. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements.

101.19 Pathologic fractures due to any cause (see 101.00J), documented by A and B:

A. Three or more medically documented pathologic fractures occurring on separate occasions within a 12-month period;

AND

B. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months, and medical documentation of at least one of the following (see 101.00E):

1. A documented medical need for a walker, bilateral canes, or bilateral crutches;
or

2. An inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements, and a documented medical need for a one-handed assistive device that requires the use of the other upper extremity; or

3. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements.

101.20 Amputation due to any cause (see 101.00K), documented by A, B, C, or D:

A. Amputation of both upper extremities, occurring at any level above the wrists (carpal joints), up to and including the shoulder (glenohumeral) joint.

OR

B. Hemipelvectomy or hip disarticulation.

OR

C. Amputation of one upper extremity, occurring at any level above the wrist (carpal joints), and one lower extremity at or above the ankle (tarsal joint), and medical documentation of one the following (see 101.00E):

1. The documented medical need for a one-handed assistive device requiring the use of the other upper extremity, or

2. The inability to use the remaining upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements.

OR

D. Amputation of one or both lower extremities at or above the ankle (tarsal joint), with complications of the residual limb that have lasted or can be expected to last for at least 12 months, and medical documentation of both 1 and 2 (see 101.00E):

1. The inability to use a prosthetic device(s); and

2. The documented medical need for a walker, bilateral canes, or bilateral crutches.

101.21 Soft tissue injury or abnormality under continuing surgical management
(see 101.00L), documented by A, B, and C in the medical record:

A. Evidence confirms ongoing surgical management directed towards saving, reconstructing, or replacing the affected part of the body.

AND

B. The surgical management has been, or is expected to be, ongoing for at least 12 months.

AND

C. Maximum benefit from therapy has not yet been achieved.

101.22 Non-healing or complex fracture of the femur, tibia, pelvis, or one or more of the tarsal bones (see 101.00M), documented by A and B and C:

A. Solid union not evident on appropriate medically acceptable imaging and not clinically solid;

AND

B. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months,

AND

C. A documented medical need for a walker, bilateral canes, or bilateral crutches (see 101.00E).

101.23 Non-healing or complex fracture of an upper extremity (see 101.00N),

Documented by A and B and C:

A. Nonunion of a fracture, or complex fracture, of the shaft of the humerus, radius, or ulna, under continuing surgical management, as defined in 1.00P, directed toward restoration of functional use of the extremity;

AND

B. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months,

AND

C. Medical documentation of at least one of the following (see 101.00E):

1. An inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements, and a documented medical need for a one-handed assistive device that requires the use of the other upper extremity; or

2. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements.

101.24 Musculoskeletal disorders of infants and toddlers, from birth to attainment of age 3, with developmental motor delay (see 101.00O), as documented by A or B:

A. A standardized developmental motor assessment that:

1. Shows motor development not more than one-half the level typically expected for child's age; or

2. Results in a valid score that is at least three standard deviations below the mean.

OR

B. Two narrative developmental reports that:

1. Are dated at least 120 days apart; and

2. Show motor development not more than one-half of the level typically expected for child's age.

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104.00 CARDIOVASCULAR SYSTEM

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F. Evaluating Other Cardiovascular Impairments

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9. What is lymphedema and how will we evaluate it?

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b. * * * We will evaluate lymphedema by considering whether the underlying cause meets or medically equals any listing or whether the lymphedema medically equals a cardiovascular listing, such as 4.11 Chronic venous insufficiency, or a musculoskeletal listing, such as 101.18 Abnormality of a major joint(s) in any extremity. * * *

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114.00 IMMUNE SYSTEM DISORDERS

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C. Definitions

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2. Assistive device(s) has the same meaning as in 101.00C6a.

5. Documented medical need has the same meaning as in 101.00C6a.

8. Fine and gross movements have the same meaning as in 101.00E4.

9. Hand-held assistive device has the same meaning as in 101.00C6d.

10. Major joint of an upper or lower extremity has the same meaning as in 101.00I1.

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D. How do we document and evaluate the listed autoimmune disorders?

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4. Polymyositis and dermatomyositis (114.05).

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c. Additional information about how we evaluate polymyositis and dermatomyositis under the listings.

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(ii) If you are of preschool age through adolescence (age 3 to attainment of age 18), weakness of your pelvic girdle muscles that results in your inability to rise independently from a squatting or sitting position or to climb stairs may be an indication that you are unable to walk without physical or mechanical assistance. * * *

* * * * *

6. Inflammatory arthritis (114.09).

a. General. * * * Clinically, inflammation of major joints in an upper or lower extremity may be the dominant manifestation causing difficulties with walking or performing fine and gross movements; there may be joint pain, swelling, and tenderness. The arthritis may affect other joints, or cause less limitation in walking or performing fine and gross movements. * * *

* * * * *

e. How we evaluate inflammatory arthritis under the listings.

(i) Listing-level severity in 114.09 Inflammatory arthritis A and C1 is shown by the presence of an impairment-related, significant limitation cited in the criteria of these listings. In 114.09A, listing-level severity is satisfied with persistent inflammation or deformity in one major joint in a lower extremity resulting in a documented medical need

for a walker, bilateral canes, or bilateral crutches as required in 114.09A1, or one major joint in each upper extremity resulting in an impairment-related, significant limitation in the ability to perform fine and gross movements as required in 114.09A2. In 114.09C1, if you have the required ankylosis (fixation) of your cervical or dorsolumbar spine, we will find that you have an impairment-related significant limitation in your ability to see in front of you, above you, and to the side. Therefore, a listing-level impairment in the ability to walk is implicit in 114.09C1, even though you might not require bilateral upper limb assistance.

(ii) Listing-level severity is shown in 114.09B and 114.09C2 by inflammatory arthritis that involves various combinations of complications of one or more major joints in an upper or lower extremity or other joints, such as inflammation or deformity, extra-articular features, repeated manifestations, and constitutional symptoms and signs. * * *

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114.01 Category of Impairments, Immune System Disorders

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114.04 Systemic sclerosis (scleroderma). As described in 114.00D3. With:

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B. One of the following:

1. Toe contractures or fixed deformity of one or both feet, resulting in one of the following:

a. A documented medical need for a walker, bilateral canes, or bilateral crutches (see 114.00C9); or

b. An inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements, and a documented medical need for a one-handed assistive device (see 114.00C9) that requires the use of the other upper extremity; or

2. Finger contractures or fixed deformity in both hands, resulting in an inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements; or

3. Atrophy with irreversible damage in one or both lower extremities, resulting in one of the following:

a. A documented medical need for a walker, bilateral canes, or bilateral crutches (see 114.00C9); or

b. An inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements, and a documented medical need for a one-handed assistive device (see 114.00C9) that requires the use of the other upper extremity; or

4. Atrophy with irreversible damage in both upper extremities, resulting in an inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements.

OR

C. Raynaud's phenomenon, characterized by:

* * * * *

2. Ischemia with ulcerations of toes or fingers, resulting in one of the following:

a. A documented medical need for a walker, bilateral canes, or bilateral crutches (see 114.00C9); or

b. An inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements, and a documented medical need for a one-handed assistive device (see 114.00C9) that requires the use of the other upper extremity; or

c. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements.

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114.05 Polymyositis and dermatomyositis. As described in 114.00D4. With:

A. Proximal limb-girdle (pelvic or shoulder) muscle weakness, resulting in one of the following:

1. A documented medical need for a walker, bilateral canes, or bilateral crutches (see 114.00C9); or

2. An inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements, and a documented medical need for a one-handed assistive device (see 114.00C9) that requires the use of the other upper extremity; or

3. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements.

* * * * *

114.09 Inflammatory arthritis. As described in 114.00D6. With:

A. Persistent inflammation or persistent deformity of:

1. One or more major joints in a lower extremity(ies) resulting in one of the following:

a. A documented medical need for a walker, bilateral canes, or bilateral crutches (see 114.00C9); or

b. An inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements, and a documented medical need for a one-handed assistive device (see 114.00C9) that requires the use of the other upper extremity; or

2. One or more major joints in each upper extremity resulting in an inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements.

OR

B. Inflammation or deformity in one or more major joints of an upper or lower extremity(ies) with: * * *

* * * * *

PART 416 — SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND,
AND DISABLED

Subpart I — [Amended]

3. The authority citation for subpart I of part 416 continues to read as follows:

Authority: Secs. 221(m), 702(a)(5), 1611, 1614, 1619, 1631(a), (c), (d)(1), and (p), and 1633 of the Social Security Act (42 U.S.C. 421(m), 902(a)(5), 1382, 1382c, 1382h, 1383(a), (c), (d)(1), and (p), and 1383b); secs. 4(c) and 5, 6(c)-(e), 14(a), and 15, Pub. L. 98-460, 98 Stat. 1794, 1801, 1802, and 1808 (42 U.S.C. 421 note, 423 note, and 1382h note).

4. Amend § 416.926a by removing paragraph (m)(1) through (m)(2) and redesignating paragraphs (m)(3) through (m)(5) as (m)(1) through (m)(3).

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