SOCIAL SECURITY ADMINISTRATION

20 CFR Parts 404 and 416

[Regulations Nos. 4 and 16]

RIN 0960-AE57

Supplemental Security Income; Determining Disability for a Child Under Age 18; Interim Final Rules With Request for Comments

AGENCY: Social Security Administration.

ACTION: Interim final rules with request for comments.

SUMMARY: These rules implement the childhood disability provisions of sections 211 and 212 of Public Law 104–193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 that provide a new definition of disability for children (i.e., individuals under age 18), mandate changes to the evaluation process for children's disability claims and continuing disability reviews (CDRs), and require that disability redeterminations be performed for 18-year-olds eligible as children in the month before they attain age 18.

DATES: These rules are effective beginning April 14, 1997. To be sure that your comments are considered, we must receive them no later than April 14, 1997.

ADDRESSES: Comments should be submitted in writing to the Commissioner of Social Security, P.O. Box 1585, Baltimore, MD 21235; sent by telefax to (410) 966–2830; sent by E-mail to ''regulations@ssa.gov''; or delivered to the Division of Regulations and Rulings, Social Security Administration, 3–B–1 Operations Building, 6401 Security Boulevard, Baltimore, MD 21235, between 8:00 a.m. and 4:30 p.m. on regular business days. Comments may be inspected during these same hours by making arrangements with the contact person shown below.

FOR FURTHER INFORMATION CONTACT: Daniel T. Bridgewater, Legal Assistant, Division of Regulations and Rulings, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235, (410) 965–3298 for information about these rules. For information on eligibility or claiming benefits, call our national toll-free number, 1–800–772–1213.

SUPPLEMENTARY INFORMATION:

History

Prior to the enactment of Public Law 104–193 on August 22, 1996, the Act defined childhood disability in relation to the definition of disability for adults. The definition of disability for adults in section 1614(a)(3) of the Act is an inability ''to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.'' Prior to August 22, 1996, the definition of disability for children (i.e., individuals under the age of 18) was contained in a parenthetical statement at the end of section 1614(a)(3)(A): A child was considered disabled for purposes of eligibility for SSI if he or she ''* * * suffer[ed] from any medically determinable physical or mental impairment of comparable severity'' to an impairment(s) that would make an adult disabled.

Social Security Administration (SSA) regulations at 20 CFR 416.920 set out a five-step sequential evaluation process for determining the disability of adults:

1. Whether the adult is engaging in substantial gainful activity;

2. Whether, in the absence of substantial gainful activity, the individual's medically determinable impairment or combination of impairments is ''severe;''

3. Whether, if the impairment(s) is severe, it meets or medically equals the severity of a listing in the Listing of Impairments in appendix 1 of subpart P of 20 CFR part 404 (the Listing);

4. Whether, if the impairment(s) is severe but does not meet or equal the severity of a listing, the individual retains the capacity to do his or her past relevant work, considering his or her residual functional capacity; and

5. Whether, if past relevant work is precluded, the individual retains the capacity to do any other kind of work which exists in significant numbers in the national economy, considering the individual's residual functional capacity and the vocational factors of age, education and work experience.

Until 1990, if a child was not engaging in substantial gainful activity and his or her impairment(s) met the statutory duration requirement, a child's claim for SSI benefits based on disability was decided based on whether or not the child's impairment(s) met or equaled the severity of a listing, as in the third step of the process for adults. We did not provide additional evaluation steps for children as we did for adults because it was inappropriate to apply the vocational rules we used for adults whose impairments do not meet or equal the severity of a listed impairment to childhood claims.

Sullivan v. Zebley

On February 20, 1990, in the case of *Sullivan* v. *Zebley*, 493 U.S. 521 (1990), the Supreme Court decided that the ''listings-only'' approach SSA had used to deny claims for SSI benefits based on childhood disability did not carry out the ''comparable severity'' standard in title XVI of the Act. This was because the listings did not provide for an assessment of a child's overall functional impairment. The Court held that, under the comparable severity standard, children claiming SSI benefits based on disability were entitled to an assessment as part of the disability determination process, comparable to adults who have impairments that do not meet or equal the severity of a listing and who receive such an individualized assessment. The Court found that, whereas adults who are not found to be disabled under the Listing still have the opportunity to show that they are disabled at the last step of the sequential evaluation process, no similar opportunity existed for children. The Court concluded that, although the vocational analysis we use in claims filed by adults is inapplicable to claims for SSI benefits based on disability filed by children, this does not mean that a functional analysis could not be applied to children's claims.

The Court also addressed various aspects of the way in which we employed the Listing in evaluating childhood disability claims. The Court stated that the policies for establishing whether a child's impairment(s) was equivalent in severity to a listed impairment ''exclude[d] claimants who have unlisted impairments or combinations of impairments that do not fulfill all the criteria for any one listed impairment.'' The Court was also concerned that all claimants be given an opportunity for an assessment of their functional limitations, including the effects of their symptoms, in establishing medical equivalence.

The Childhood Rules That Resulted From Zebley

As a result of the *Zebley* decision, we revised the rules we used to evaluate childhood disability claims under SSI. The rules were first published in the Federal Register on February 11, 1991 (56 FR 5534) as a final rule with a request for comments. Following consideration of public comments, we published a final rule in the Federal Register on September 9, 1993 (58 FR 47532).

In § 416.924(a) of the prior rules, we defined the term ''comparable severity'' in terms of the impact of an impairment

or a combination of impairments on a child's ability to function independently, appropriately, and effectively in an age-appropriate manner. The rules also provided that each child whose impairment(s) did not meet or medically or functionally equal the requirements for any listing would have an ''individualized functional assessment'' (IFA), an evaluation of the impact of the child's impairment(s) on his or her overall ability to function independently, appropriately, and effectively in an age-appropriate manner.

In fact, the rules provided three steps at which we would consider a child's functioning. At each of these steps, we considered the impact of all of the child's medically determinable impairments on his or her functioning and considered all relevant evidence, including the effects of the individual's symptoms and the side effects of medication. We considered the nature of the impairment(s), the child's age, the child's ability to be tested given his or her age, the child's ability to perform age-appropriate daily activities, and other relevant factors.

First, we added a ''severe impairment'' step for children to parallel step 2 of the adult sequential evaluation process. At this step, the threshold for further evaluation was whether a child had more than a slight abnormality or a combination of slight abnormalities that caused more than minimal limitation in a child's ability to function independently, appropriately, and effectively in an age-appropriate manner.

Second, at step 3 of the sequential evaluation process, we expanded the rules for determining equivalence to the Listing. The new ''functional equivalence'' rule was intended, among other things, to address the Supreme Court's concerns about our use of the Listing in childhood cases. Functional equivalence provided that, if a child's impairment(s) did not meet or medically equal the severity of any listed impairment, we would assess the child's functional limitations and compare those limitations with the disabling functional consequences of any listed impairment, without regard to whether the listed impairment chosen for comparison was medically ''related'' to the child's impairment(s); for example, functional equivalence permits comparison of the functional limitations caused by a physical impairment with the functional limitations establishing disability in the mental disorders listings.

Last, for those children whose impairments were not of listing-level severity, the rules resulting from the *Zebley* decision included an entirely new fourth step in the sequential evaluation process for children. At this step, we used the IFA to assess whether a child's severe impairment(s), while not of listing-level severity, was nonetheless of ''comparable severity'' to an impairment(s) that would disable an adult.

The IFA addressed the functional impact of a child's impairment(s) in broad areas of functioning, which we called domains and behaviors, such as cognition, communication, and motor abilities. These domains and behaviors were intended to encompass and reflect all the things that a child may do at any particular age, and were, therefore, intended to include all of a child's functioning.

If an IFA showed that a child's impairment(s) substantially reduced his or her ability to function independently, appropriately, and effectively in an age-appropriate manner, and the impairment(s) met the duration requirement, we found the impairment(s) to be of comparable severity to an impairment that would result in disability in an adult, and the child would, therefore, be considered disabled. If the impairment(s) did not substantially reduce the child's ability to function independently, appropriately, and effectively in an age-appropriate manner, or if it did not meet the duration requirement, we found the child was not disabled. For most children, the rules provided examples of how ''marked'' and ''moderate'' limitations in the domains and behaviors would indicate whether there was a substantial reduction in functioning; for example, ''moderate'' limitations in three domains would generally, though not invariably, result in a finding of disability.

Summary of the Childhood Disability Provisions of Public Law 104–193

Public Law 104–193 provides a new statutory definition of disability for children claiming SSI benefits and directs us to make significant changes in the way we evaluate childhood disability claims. Under the new law, a child's impairment or combination of impairments must cause more serious impairment-related limitations than the old law and our prior regulations required.

Section 211(a) of Public Law 104–193 amended section 1614(a)(3) of the Act to provide a definition of disability for children separate from that for adults. The ''comparable severity'' criterion in the Act was repealed and replaced with the following definition:

> (C)(i) An individual under the age of 18 shall be considered disabled for the purposes of this title if that individual has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.
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> (ii) Notwithstanding clause (i), no individual under the age of 18 who engages in substantial gainful activity (determined in accordance with regulations prescribed pursuant to subparagraph (E)) may be considered to be disabled.

The conference report that accompanied Public Law 104–193 further explained:

> The conferees intend that only needy children with severe disabilities be eligible for SSI, and the Listing of Impairments and other current disability determination regulations as modified by these provisions properly reflect the severity of disability contemplated by the new statutory definition. In those areas of the Listing that involve domains of functioning, the conferees expect no less than two marked limitations as the standard for qualification. The conferees are also aware that SSA uses the term ''severe'' to often mean ''other than minor'' in an initial screening procedure for disability determination and in other places. The conferees, however, use the term ''severe'' in its common sense meaning.

H.R. Conf. Rep. No. 725, 104th Cong., 2d Sess. 328 (1996), *reprinted in* 1996 U.S. Code, Cong. and Ad. News 2649, 2716. The House report contains similar language. See H.R. Rep. No. 651, 104th Cong., 2d Sess. 1385 (1996), *reprinted in* 1996 U.S. Code, Cong. and Ad. News 2183, 2444.

Further provisions concerning childhood disability adjudication are summarized below with references to the relevant sections of Public Law 104–193.

- The Commissioner was directed to remove references to maladaptive behavior in the personal/behavioral domain from listings 112.00C2 and 112.02B2c(2) of the childhood mental disorders listings (Section 211(b) (1)).
- The Commissioner was directed to discontinue the IFA for children in 20 CFR 416.924d and 416.924e (Section 211(b) (2)).
- Within 1 year after the date of enactment, we must redetermine the eligibility of individuals under the age of 18 who were eligible for SSI based on disability as of August 22, 1996, and whose eligibility may terminate by reason of the new law. The cases are to be redetermined using the eligibility criteria for new applicants. The medical improvement review standard in section 1614(a) (4) of the Act and 20 CFR 416.994a, used in CDRs, shall not apply

to these redeterminations (Section 211(d) (2)).

- The medical improvement review standard for determining continuing eligibility for children was revised to conform to the new definition of disability for children (Section 211(c)).
- Not less frequently than once every 3 years, we must conduct a CDR for any childhood disability recipient eligible by reason of an impairment(s) which is likely to improve. At the option of the Commissioner, we may also perform a CDR with respect to those individuals under age 18 whose impairments are unlikely to improve (Section 212(a)).
- We must redetermine the eligibility of individuals who were eligible for SSI based on disability in the month before the month in which they attained age 18 using the rules for determining initial eligibility for adults. We will do the redetermination during the 1-year period beginning on the individual's 18th birthday. The medical improvement review standard used in CDRs does not apply to these redeterminations (Section 212(b)).
- We must conduct a CDR not later than 12 months after the birth of the child for any child whose low birth weight is a contributing factor material to our determination that the child was disabled (Section 212(c)).
- At the time of a CDR, a child's representative payee shall present evidence that the child is and has been receiving treatment to the extent considered medically necessary and available for the disabling impairment. If a payee refuses without good cause to provide such evidence, we may select another representative payee, or pay benefits directly to the child, if we determine that it is appropriate and in the best interests of the child (Section 212(a)).

These rules implement all of the provisions of sections 211 and 212 of Public Law 104–193, with the exception of section 211(d)(2). Because Public Law 104–193 repealed the ''comparable severity'' disability standard for children, and eliminated use of the IFA, step 4 of our prior sequential evaluation process (the comparable severity step) has been removed. To be found disabled under these rules, an individual under age 18 must have ''marked and severe functional limitations,'' which means that his or her impairment or combination of impairments must meet, or medically equal or functionally equal, the severity of a listed impairment.

Summary of Specific Revisions

These interim final rules revise our prior rules for deciding initial eligibility and continuing eligibility for children claiming SSI benefits based on disability. They also provide rules for redetermining the eligibility of individuals who attain age 18 and who were eligible for SSI based on disability in the month before the month in which they attained age 18.

The major changes to the rules are explained below. In addition, we have added, removed, and revised language throughout subpart I of 20 CFR part 416 to remove references to the ''comparable severity'' standard and our prior regulatory definition of disability interpreting that standard. Since these are only conforming changes to comply with the new law, we have not summarized each of them in this summary.

These rules do not address every aspect of the evaluation of disability of children and of individuals who have attained age 18. They implement primarily those changes required by Public Law 104–193. Therefore, they must be read in the context of all our other relevant rules for determining disability.

Appendix 1 to Subpart P of Part 404—Listings 112.00C and 112.02B2

Public Law 104–193 mandates removal of references to ''maladaptive behaviors'' in listings 112.00C2 and 112.02B2c(2) in the childhood mental disorders section of the Listing of Impairments. Listing 112.00C explains the severity criteria we use to evaluate a mental impairment in most of our childhood mental disorder listings. These severity criteria are often referred to as the ''paragraph B'' criteria because they are found in paragraph B of most of the listings to which they apply. Listing 112.02B2c(2) was a particular paragraph B criterion for persistent, serious maladaptive behaviors in children aged 3 to 18. Pursuant to Public Law 104–193, we have removed all references to ''maladaptive behaviors'' in listing 112.00C and deleted all of prior listing 112.02B2c(2); we have also redesignated the ''personal/behavioral'' area as the area of ''personal function.'' For this reason, we also removed the reference to ''activities of daily living'' from former listing 112.02B2c(1), which we now designate as listing 112.02B2c because it is the only paragraph remaining.

The area of personal function now pertains only to self-care; that is, the ability to help oneself and to cooperate with others in taking care of personal needs, health, and safety (e.g., feeding, dressing, toileting, bathing, following medication regimes, and following safety precautions). Further, we have clarified the description of the social area of functioning to make it clearer that many impairment-related behavioral problems (including those previously considered in the prior personal/behavioral area) are likely to have their most significant effects on a child's social functioning.

In addition, we revised the fourth area of function from ''concentration, persistence, and pace'' to ''concentration, persistence, or pace.'' This is a technical correction to conform the language of this section to the rules in listings 112.00C3 and 112.02B2d, which have always read ''deficiencies of concentration, persistence, or pace.'' We made a corresponding change in listing 112.00C4, which also used the word ''and.'' We also made several clarifications in listing 112.00C2b. The changes are not substantive and are only intended to parallel the adult mental listing 12.00C2 with appropriate language for children.

Section 416.635 Responsibilities of a Representative Payee.

We revised this section to provide that, in cases in which the beneficiary is an individual under age 18 (including cases in which the beneficiary is an individual whose low birth weight is a contributing factor material to our determination that the individual is disabled), the representative payee is responsible for ensuring that the beneficiary is and has been receiving treatment to the extent considered medically necessary and available for the condition that was the basis for providing benefits.

Section 416.902 General Definitions and Terms for This Subpart

We have added four new definitions. First, we explain that a *disability redetermination* (see § 416.987) is a redetermination of eligibility based on disability using the rules for new applicants appropriate to the individual's age, except the rules pertaining to performance of substantial gainful activity. Second, we explain that the term *impairment(s)* means ''a medically determinable physical or mental impairment or a combination of medically determinable physical or mental impairments.''

Third, we explain that the term *marked and severe functional limitations,* when used as a phrase, means the standard of disability in the Act for children claiming SSI benefits, and is a level of severity that meets or medically or functionally equals the requirements of a listing. We explain that the separate words *Marked* and *severe* are also terms used throughout

this subpart, but the meanings of these words in the phrase *marked and severe functional limitations* is not the same as their meanings when used separately. The meaning of the phrase *marked and severe functional limitations* derives directly from the legislative history of Public Law 104–193, quoted in the ''Summary of the Childhood Disability Provisions of Public Law 104–193,'' above. Since the meanings of the separate terms *marked* and *severe* predate enactment of Public Law 104–193, they are touched on in this section to minimize any confusion from the new law's use of the same words, used in combination with a different meaning. Finally, we define *Commissioner* to mean the Commissioner of Social Security.

Section 416.906 Basic Definition of Disability for Children

We have revised this section to replace the prior ''comparable severity'' standard with the new ''marked and severe functional limitations'' standard for childhood disability. We also added the statutory provision that an individual under age 18 who files a new claim and who is engaging in substantial gainful activity will not be considered disabled. For clarity, we added language specifying our longstanding policy that we consider the effects of combined impairments in assessing whether a child is disabled.

Section 416.911 Definition of Disabling Impairment

Under the Act and our regulations, individuals who file new applications for benefits based on disability and who are engaging in substantial gainful activity are found not disabled. However, after a disabled individual is eligible for SSI, the Act and our regulations permit some individuals to try to work without losing eligibility. A recipient of SSI benefits who begins or returns to work despite a ''disabling impairment'' may be found eligible for special SSI cash benefits and for special SSI eligibility status under §§ 416.260 ff. of our regulations.

Section 416.911 provides the definition of the term ''disabling impairment'' for such cases. We have redesignated all but the last sentence of prior § 416.911, which was applicable only to adults, as paragraph (a)(1), and added a paragraph (b)(1) to define ''disabling impairment'' for children. Final paragraph (a)(2) takes account of the new rules in § 416.987 for the disability redeterminations required by section 212(b) of Public Law 104–193. Consistent with this section of the new law, the rules explain that, for disability redetermination cases of individuals who are age 18, and who were eligible for SSI benefits based on a disability for the month before the month in which they attained age 18, a disabling impairment is one that meets the criteria for initial eligibility set forth in §§ 416.920(c) through (f) for adults. This is because the new law specifies that these disability redeterminations shall apply the eligibility criteria for new applicants, and not the medical improvement review standard provisions of section 1614(a)(4) of the Act applicable to CDRs. However, step 1 of the sequential evaluation process for new claims (the substantial gainful activity step) will not apply. For individuals affected by this provision who have a disabling impairment, and who are working, we will apply the rules in §§ 416.260 ff. We redesignated as paragraph (c) the last sentence of prior § 416.911, which provides that earnings are not considered in deeming whether a recipient has a disabling impairment(s), because it applies to both adults and children.

Section 416.919n Informing the Examining Physician or Psychologist of Examination Scheduling, Report Content, and Signature Requirements

We have amended § 416.919n(c)(6), which concerns the opinion of a consulting physician or psychologist about an individual's ability to function despite his or her impairment(s), to add a discussion specific to childhood cases to make it clear that the provision applies to both adults and children.

Section 416.924 How We Determine Disability for Children

We have extensively revised this section, which provides the sequential evaluation process for childhood disability claims, to conform to the provisions of Public law 104–193.

We have deleted former paragraphs (a) and (f). Prior paragraph (a) defined *comparable severity* and prior paragraph (f) discussed the IFA. We redesignated prior paragraphs (b) through (e) as (a) through (d), and revised them as explained below. We added a new paragraph (e) to explain what we will do when children become adults (i.e., they attain age 18) after they file their applications for SSI benefits based on disability but before we make a determination or decision. We redesignated prior paragraph (g) as paragraph (f), but it is otherwise unchanged. Also, we added a new paragraph (g).

In final § 416.924, the new sequential evaluation process for determining initial eligibility is:

1. Whether the child is engaging in substantial gainful activity;

2. If not, whether the child has a medically determinable impairment or combination of impairments that is severe; and

3. If the child's impairment(s) is severe, whether it meets or medically equals the requirements of a listing, or whether the functional limitations caused by the impairment(s) are the same as the disabling functional limitations of any listing and, therefore, functionally equivalent to such listing.

As in the prior sequential evaluation process, we will follow the steps in order. If a determination or decision can be made at a step, we will stop; if not, we will proceed to the next step.

New § 416.924(a), ''Steps in evaluating disability,'' retains basic guidance from prior § 416.924(b) that is unaffected by the new law. It continues to provide that we will consider all relevant evidence in a child's case record, that we will consider all impairments for which we have evidence and their combined effects, and that we will evaluate any limitations in a child's functioning that result from a child's symptoms, including pain. We have removed the reference to the prior IFA step and made minor revisions to reflect the new statutory standard and the new sequence of evaluation. Because meeting or equaling the severity of a listing is now the last step of the sequence, we have emphasized the importance of the step by specifying that a child will be disabled if his or her impairment(s) meets, medically equals, or functionally equals the severity of any listing. We also changed references to the ''ability to function'' to ''functioning'' in order to conform to the new statutory definition of disability, which is now expressed in terms of ''marked and severe functional limitations.''

Final paragraphs (b) through (d) provide more detail on the sequential evaluation steps outlined in paragraph (a). Final paragraph (b), ''If you are working,'' is the same as prior paragraph (c). A child who files a new application, and who is engaging in substantial gainful activity, will be found not disabled as required by the statute. Final paragraph (c), ''You must have a severe impairment(s),'' is substantively the same as prior paragraph (d), but revised to reflect the new law. At step two of the sequential process, we will continue to evaluate whether a child has a ''severe'' impairment or combination of impairments. We now provide that if a child has a slight abnormality or a combination of slight abnormalities that

causes no more than minimal functional limitations, we will find that the child does not have a severe impairment and, therefore, is not disabled. The phrase ''minimal functional limitations'' replaces the phrase from our prior rules ''minimal limitation in your ability to function, independently, appropriately, and effectively in an age-appropriate manner,'' which, as noted above, was derived from the prior statutory definition of disability.

Final paragraph (d) ''Your impairment(s) must meet, medically equal, or functionally equal in severity a listed impairment in appendix 1,'' explains that an impairment(s) causes marked and severe functional limitations if it meets, medically equals or functionally equals the severity of a listed impairment. Thus, if a child's impairment(s) meets, medically equals, or functionally equals in severity a listing (and meets the duration requirement), we will find the child disabled. If a child's impairment(s) does not meet or medically equal or functionally equal in severity any listing, or does not meet the duration requirement, we will find the child not disabled. We have removed the language from prior paragraph (e) that said a child's claim would not be denied because his or her impairment(s) was not of listing-level severity.

We added a new paragraph (e), ''If you attain age 18 after you file your disability application but before we make a determination or decision,'' to explain what we will do in such cases. We will use the rules for determining disability in adults when an individual whom we found disabled prior to attaining age 18 attains age 18. (We have always used the adult disability rules beginning at age 18 when we find that an individual was *not* disabled prior to attaining age 18 to see if the individual became disabled at a later date.) Therefore, final paragraph (e) explains that, for the period during which the individual is under age 18, we will use the disability rules in § 416.924, but for the period starting with the day the individual attains age 18, we will use the disability rules for adults filing new claims in § 416.920.

Except for redesignating prior paragraph (g) as final paragraph (f), ''Basic considerations,'' has not been changed. We will continue to consider all relevant medical and nonmedical evidence in a child's case record.

Finally, we have added a new paragraph (g) to explain that, when we make an initial or reconsidered determination whether you are disabled or when we make an initial determination about whether your disability continues under section 416.994a, we will complete a standard form, Form SSA–538, Childhood Disability Evaluation Form. The new form is designed to guide our adjudicators through the new sequential evaluation process and emphasizes the requirements for establishing functional equivalence. In new paragraph (g), we also explain that disability hearing officers, administrative law judges, and the administrative appeals judges on the Appeals Council (when the Appeals Council makes a decision) will not complete the form. This is because these adjudicators issue decisions with detailed rationales and findings that will already reflect the steps of the new sequential evaluation process.

Section 416.924a Age as a Factor of Evaluation in Childhood Disability

Most of the guidance in our prior rules on consideration of age in childhood disability cases has not been changed by Public Law 104–193. We have revised this section to conform to the ''marked and severe functional limitations'' disability standard. As under our prior rules, we will consider the child's age in determining whether he or she has a severe impairment(s). When evaluating whether the impairment(s) meets, medically equals, or functionally equals the severity of a listing, we will consider the child's age if the listing we consider uses age categories. We have deleted prior paragraphs (a)(4) and (b), which addressed issues related to the IFA.

We redesignated prior paragraph (c), ''Correcting chronological age of premature infants,'' and prior paragraph (d), ''Age and the impact of severe impairments on younger children and older adolescents,'' as final paragraphs (b) and (c) and made changes to conform to the new definition of disability; we deleted prior paragraph (d)(4)(ii) because it was based on the prior ''comparable severity'' standard.

Section 416.924b Functioning in Children

This section discusses some of the terms we use to describe or evaluate functioning in children, including age-appropriate activities, developmental milestones, activities of daily living, and work-related activities. We retained the discussions of these terms with appropriate conforming changes. We also clarified the explanations of the last three terms, which were described in our prior rules as ''*the* most important indicators of functional limitations'' in, respectively, infants up to attainment of age 3, children aged 3 to attainment of age 16, and older adolescents aged 16 to attainment of age 18. In the interim final rules, we describe these functions as being ''most important as indicators of functional limitations,'' because the emphasis should be on whatever age groups for which these indicators of functional limitations are most appropriate.

Although we deleted prior paragraph (b)(5) because it described the domains and behaviors used in performing an IFA under our prior rules, consideration of functional limitations remains an integral part of the childhood disability evaluation process. For example, final § 416.926a describes areas of functioning we will consider when we evaluate whether a child's impairment(s) is functionally equivalent in severity to a listing.

Section 416.924c Other Factors We Will Consider

As under our prior rules, when we evaluate whether a child's impairment(s) is disabling, we will consider all relevant factors, such as the effects of medications, the setting in which the child lives, the child's need for assistive devices, and the child's functioning in school. However, as throughout these interim final rules, we have revised this section to conform to the statutory ''marked and severe functional limitations'' standard.

Section 416.924d Individualized Functional Assessment for Children

Section 416.924e Guidelines for Determining Disability Using the Individualized Functional Assessment

We deleted both of these sections as required by section 211(b)(2) of Public Law 104–193.

Section 416.925 Listing of Impairments in Appendix 1 of Subpart P of Part 404 of This Chapter

We have revised paragraph (a) of this section, ''Purpose of the Listing of Impairments,'' to explain that, for children, the Listing of Impairments describes impairments that are considered severe enough to result in marked and severe functional limitations. We revised paragraph (b)(2), which explains the purpose of the childhood listings in part B of the Listing, to explain that the level of severity of the impairments listed in part B is intended to be the same as that expressed in the functional severity criteria of the childhood mental disorders listings (see 112.01 ff.). Therefore, in general, a child's impairment(s) is of ''listing-level severity'' if it results in marked limitations in two broad areas of functioning, or extreme limitations in

one such area. However, we also explain that when we decide whether a child's impairment(s) meets the requirements for any listed impairment, we will decide that the impairment is of ''listing-level severity'' even if it does not result in marked limitations in two broad areas of functioning, or extreme limitations in one such area, if the listing that we apply does not require such limitations to establish that an impairment(s) is disabling. We also explain that we define the terms ''marked'' and ''extreme'' as they apply to children in § 416.926a.

Section 416.926 Medical Equivalence for Adults and Children

In these interim final rules, we moved the rules for deciding whether a child's impairment(s) is medically equivalent in severity to any listing into the same section as the rules for deciding medical equivalence of impairments in adults, reserving § 416.926a for functional equivalence. To make this clear, we revised the heading of final § 416.926 to reflect the inclusion of children. We also revised final paragraph (a), ''How medical equivalence is determined,'' by replacing the explanation of how we determine medical equivalence with provisions from prior § 416.926a. We also incorporated and revised the last sentence of prior § 416.926a(a), explaining that we consider all relevant evidence in the case record when we decide the issue of medical equivalence because it remains applicable to both adults and children.

We decided to use the provisions of former § 416.926a(b) to explain our rules for determining medical equivalence for both adults and children. This is not a substantive change, but a clearer statement of our longstanding policy on medical equivalence than was previously included in prior § 416.926(a), as it was clarified for children in prior § 416.926a(b). This merely allows us to address only once in our regulations the policy of medical equivalence, which is and always has been the same for adults and children. (Although some of the text of § 416.929(a) will differ from the text of § 404.1526(a), both sections, which are in chapter III of title 20 of the Code of Federal Regulations, will continue to provide the same substantive rules.)

We have also added a new paragraph (d), ''Responsibility for determining medical equivalence,'' to address our longstanding policy of who is responsible for determining medical equivalence for adults and children.

Section 416.926a Functional Equivalence for Children

Although Public Law 104–193 discontinued the use of the IFA, the legislation nevertheless emphasized that we were still to continue evaluating the functioning of children in our disability assessments, as shown by the news statutory definition of disability, ''marked and severe functional limitations.''

Moreover, in the legislative history, the conferees stated:

* * * Where appropriate, the conferees remind SSA of the importance of the use of functional equivalence disability determination procedures.

* * * [T]he conferees do not intend to suggest by this definition of childhood disability that every child need be especially evaluated for functional limitations, or that this definition creates a supposition for any such examination. * * * Nonetheless, the conferees do not intend to limit the use of functional information, if reflecting sufficient severity and is otherwise appropriate.

H.R. Conf. Rep. No. 725, 104th Cong, 2d Sess. 328 (1996), *reprinted in* 1996 U.S. Code, Cong. and Ad. News 2649, 2716. The House Report also contained similar language about the importance of functional information. See H.R. Rep. No. 651, 104th Cong., 2d Sess. 1385–1386 (1996), *reprinted in* 1996 U.S. Code, Cong. and Ad. News 2183, 2444–2445.

Thus, even though it eliminated the IFA, Congress directed us to continue to evaluate a child's functional limitations where appropriate, albeit using a higher level of severity than under the former IFA. Congress also explicitly endorsed our functional equivalence policy as a means for evaluating impairments that would not meet or medically equal any of our listings and without which some needy children with severe disabilities would not be eligible.

Therefore, we are retaining our prior policies on determining functional equivalence. Because the changes made by Public Law 104–193 make the functional equivalence provision that last point of adjudication in a child's claim and, therefore, critical to the outcome of many cases, we are also clarifying these rules.

When we published the prior rules in the Federal Register on September 9, 1993, we chose not to adopt a number of public comments about our policy of ''functional equivalence.'' Some commenters on the 1993 rules thought that, because the functional equivalence policy was unfamiliar, it was important that we provide as much detail as possible in the regulations so that all adjudicators would understand and apply the new rules in the same way. Several commenters also said that § 416.926a should explain the ''thought processes'' an adjudicator could employ to make a finding of functional equivalence; otherwise, the policy of functional equivalence might be under-utilized. One suggestion was that we incorporate into the rules the more detailed instructions in our operating manuals and training guides. One commenter suggested that we provide separate headings for medical equivalence and functional equivalence to highlight their differences and the novelty of the functional equivalence policy.

Although we did not adopt the comments in 1993, we have made changes in these rules that respond to some of the earlier concerns of 1993 to reflect the increased importance of the functional equivalence policy under the new law.

First, as noted in the explanation of § 416.926, we have separated the discussion of medical equivalence for children from the discussion of functional equivalence for children. We have also incorporated some of the more detailed explanations from our operating manuals regarding the application of functional equivalence.

Final paragraph (a), ''General,'' and final paragraph (b), ''How we determine functional equivalence,'' now include, in reorganized form, the rules for functional equivalence previously in § 416.926a(a) and (b)(3). As already indicated, we moved prior (b)(1) and (b)(2), which explained medical equivalence, to § 416.926. Because of the reorganization, we deleted the second sentence from prior paragraph (b)(3) (''If you have more than one impairment, we will consider the combined effects of all your impairments on your overall functioning.'') because it would have been redundant.

In final paragraph (b), we also included some of the more detailed guidelines concerning functional equivalence that commenters on the 1993 childhood disability rules requested that we include in the regulations, and that we believe are necessitated by the new definition of disability. This paragraph explains that there are several methods for determining functional equivalence, and that we may use any one of them to determine whether an impairment is functionally equivalent in severity to a listing. Subparagraphs then explain the various methods that we may employ to determine functional equivalence. We explain that there is no set order in which we must apply these methods and that, when we find that an

impairment(s) is functionally equivalent to a listed impairment, we will use any method that is appropriate to, or best describes, a child's impairment(s) and functional limitations. However, we explain that will consider all of the methods before we decide that an impairment(s) is not functionally equivalent in severity to any listed impairment and refer to final § 416.924(g), which explains how we will use the new Childhood Disability Evaluation Form, Form SSA–538, at the initial and reconsideration levels.

In (b)(1), we explain the first method we may use. An impairment(s) may be functionally equivalent in severity to a listed impairment because of extreme limitations in one specific function, such as walking or talking, or based on a combination or more than one, but less medically severe, specific functional limitations, such as walking and talking. In (b)(2), we explain that an impairment(s) may be functionally equivalent to a listed impairment if it causes functional limitations in broad areas of development or functioning (e.g., in motor or social functioning) that are equivalent in severity to the disabling functional limitations in listing 112.12 or listing 112.02. (The areas of functioning in which an impairment(s) may be evaluate are discussed in paragraph (c), described below.) In (b)(3), we explain that an impairment(s) may be functionally equivalent to a listed impairment if it is chronic and characterized by frequent episodes of illness or attacks, or by exacerbations and remissions. In such cases, we may compare a child's functional limitations to those in any listing for a chronic impairment with similar episodic criteria. In (b)(4), we explain that an impairment(s) may be functionally equivalent to a listed impairment if it requires treatment over a long period of time (at least a year) and the treatment itself (e.g., multiple surgeries) causes marked and severe functional limitations, or if the combined effects of limitations caused by ongoing treatment and limitations caused by the impairment(s) result in marked and severe functional limitations.

In final paragraph (c), ''Board areas of development or functioning,'' we explain that listing 112.12, for infants (especially infants who are too young to test) and listing 112.02 are the listings we will use for comparison when we use this method of functional equivalence. However, when we determine functional equivalence based on broad functional limitations, we will evaluate the functional effects of an impairment(s) in several areas of development or functioning specified in this paragraph of § 416.926a instead of referring to the listings themselves. We also explain that we describe the areas of functioning in general terms in (c)(4) and in more detail for specific age groups in (c)(5). If we find ''marked limitations'' in two areas of development or functioning, or ''extreme limitations'' in one area, we will find that an impairment(s) is functionally equivalent to listing 112.12 or listing 112.02. Even though the listings we use for reference are mental disorder listings, this evaluation may be done for a physical impairment(s) or for a combination of physical and mental impairments. We define the terms ''marked limitations'' and ''extreme limitations'' in (c)(3).

In (c)(1), we explain how we use the areas of development or functioning: We consider the extent of functional limitations in the areas affected by an impairment(s) and how limitations in one area affect development or functioning in other areas. Thus, when a physical impairment(s) produces global limitations (i.e., limitations in the motor area and at least one other area), those limitations must be evaluated in all relevant areas. We also make reference to new areas of motor development and functioning we have added to ensure appropriate consideration of physical impairments.

In (c)(2), ''Other considerations,'' we explain that we will consider all information in the case record that will help us determine the effect of an impairment(s) on a child's physical and mental functioning. We will consider the nature of the impairment(s), the child's age, the child's ability to be tested given his or her age, the child's need for help from others (and whether such need is age-appropriate), and other relevant factors.

In (c)(3), we define the terms ''marked'' and ''extreme'' limitations. The definitions are not new, but are based on longstanding policy in the regulations and interpretations we have used in our internal instructions and training. In (c)(4) and (c)(5), we describe the areas of development or functioning that may be addressed in a determination of functional equivalence, including the new areas of motor development and motor functioning and the revised ''personal'' area of functioning. The descriptions are based on our prior descriptions and changes mandated by Public Law 104–193, and contain several clarifications based on our experience evaluating functional equivalence in children since 1991.

Final paragraph (d), ''Examples of impairments that are functionally equivalent in severity to a listed impairment,'' is substantively the same as prior paragraph (d), ''Examples of impairments of children that are functionally equivalent to the listings.'' We made minor editorial changes for clarity and, as throughout the rules, to conform the language to the changes in the law. We also updated examples (1) and (11) to remove examples of cardiovascular impairments that are now listed impairments and, therefore, no longer examples of equivalence. We changed example (4) to delete reference to a ''marked inability to stand and walk'' because the limitation described is actually ''extreme.'' We changed example (5) to show how the area of motor functioning may be used. We also clarified the primary purpose of example (10), which is primarily for children who are too young to test and for whom a diagnosis and other medical findings may be difficult to specify.

Section 416.927 Evaluating Medical Opinions About Your Impairment(s) or Disability

We have added a description of the ''marked and severe functional limitations'' standard for children to paragraph (a), ''General,'' which already included a description of the disability standard for adults.

Section 416.929 How We Evaluate Symptoms, Including Pain

Throughout this section, we have replaced references to a child's ability to ''function independently, appropriately, and effectively in an age-appropriate manner'' with references to the child's ''functioning.'' The rules for evaluating a child's symptoms are otherwise unchanged by the new law.

Section 416.930 Need To Follow Prescribed Treatment

This section explains that, in order to receive benefits, an individual must follow treatment prescribed by his or her physician if the treatment can restore his or her ability to work; i.e., if the treatment could end the individual's disability. We have added parallel language explaining that a child must follow prescribed treatment if the treatment can reduce his or her functional limitations so that they are no longer ''marked and severe.''

Section 416.987 Disability Redeterminations for Individuals Who Attain Age 18

This section is new. It provides rules for disability redeterminations

mandated by section 212(b) of Public Law 104–193.

In paragraphs (a)(1) and (a)(2), we explain that Public Law 104–193 requires these redeterminations and that, when we do these disability redeterminations, we generally will use the rules for adults filing new claims, not the rules we use for CDRs.

In paragraph (a)(3) we explain that we will notify individuals before we begin a disability redetermination. In paragraph (a)(4) we explain that we will notify the individual in writing of the results of the redetermination and explain the individual's rights in connection with our notice of disability redetermination.

Paragraph (b) concerns a group of recipients who are subject to disability redeterminations under section 212(b) of the new law: individuals who became eligible by reason of disability prior to attaining age 18, and who were eligible for SSI benefits based on disability for the month before the month in which they attained age 18. Paragraphs (b)(1) through (b)(7) of this section provide that, during the 1-year period beginning on the individual's eighteenth birthday, we will redetermine the eligibility of these individuals using the rules in §§ 416.920 (c) through (f), and not the rules in § 416.920(b) or § 416.994; i.e., we will decide whether an individual is disabled using the rules for adults filing new claims, except the rule that says an individual engaging in substantial gainful activity will be found not disabled. If an individual age 18 or older has a ''disabling impairment'' as defined in § 416.911 and is working, we will apply the rules for special SSI eligibility in §§ 416.920ff. We also provide that eligibility will end if we find that the individual is not disabled and describe the month in which we may find an individual not disabled. Finally, we explain that, if we find an individual is not disabled, the last month for which benefits can be paid is the second month after the month in which the individual was determined not to be disabled.

Section 416.990 When and How Often We Will Conduct a Continuing Disability Review

In paragraph (b), ''When we will conduct a continuing disability review,'' we have added a new paragraph (b)(11), mandated by Public Law 104–193. The new paragraph provides that we will do a CDR by a child's first birthday if the child's low birth weight is a contributing factor material to the determination that the child is disabled; i.e., whether we would have found the child disabled if we had not considered the child's low birth weight.

In paragraph (c), ''Definitions,'' we have revised the definition of a *permanent impairment, medical improvement not expected,* to explain that for a child, such an impairment is one that is unlikely to improve to the point that the child's functional limitations will no longer be marked and severe.

Section 416.994a How We Will Determine Whether Your Disability Continues or Ends, and Whether You Are and Have Been Receiving Treatment That Is Medically Necessary and Available, Disabled Children

We revised this section extensively to comport with provisions in Public Law 104–193 in two ways:

- To revise the medical improvement review standard (MIRS) used in conducting a CDR, and
- To add rules that, at the time of a CDR, a child's representative payee must show evidence that the child is and has been receiving treatment that is medically necessary and available for the condition that was the basis for providing SSI benefits.

The new evaluation sequence for applying the medical improvement review standard in a CDR is:

1. Has there been medical improvement in the impairment(s) on which eligibility was based? If there has been no medical improvement, we will find that the child is still disabled, unless certain exceptions apply.

2. If there has been medical improvement, does the impairment(s) the child had at the time of our most recent favorable medical determination or decision still meet, medically equal, or functionally equal the severity of the listing that it met or equalled at the time of the prior determination or decision? If that impairment(s) still meets or equals the severity of that listed impairment as it was written at that time, we will find the child still disabled, unless certain exceptions apply.

3. If that impairment(s) does not still meet or equal the severity of that listed impairment as it was written at that time, is the child now disabled, taking into consideration all current impairments.

Because the childhood disability standard is no longer linked to the adult standard of inability to work, there is no longer a step to assess whether any medical improvement is ''related to the ability to work.''

In paragraph (a)(1), we changed the outline of the sequential evaluation process for CDRs in childhood disability cases to reflect the new sequence of evaluation. The sequence outlined in paragraph (a)(1) and discussed in more detail in paragraphs (b)(1) through (b)(3) differs significantly from the sequence under our prior rules. In our prior rules, the first step of the CDR evaluation process for children required consideration of whether the child's impairment(s) met, or was equivalent in severity to, a listing. However, the new statutory definition of disability for children—''marked and severe functional limitations''—means a level of severity that meets or is medically or functionally equivalent in severity to the severity of a listing. Thus, if we were first to consider whether the child's impairment(s) is of listing-level severity, we would also be deciding whether that impairment(s) is disabling. In those instances in which the impairment(s) is found neither to meet nor to be equivalent in severity to any listing, we believe it would be difficult for an adjudicator to then fairly consider the issue of medical improvement, because the adjudicator would already have concluded that the child is not disabled. Section 1614(a)(4)(B) of the Act states that, with some exceptions, disability can be found to have ceased only if there is ''substantial evidence which demonstrates that there has been medical improvement * * * and that [the] impairment or combination of impairments no longer results in marked and severe functional limitations.''

Thus, to ensure proper consideration of the issue of medical improvement, we have placed that issue first in the sequence. If there has been no medical improvement, we will generally find that the child is still disabled. There are exceptions to this rule, set forth in final paragraphs (e) and (f) of this section and discussed below.

Under our prior rules, pursuant to the MIRS provisions in the Act at that time, if there had been medical improvement, we considered whether the improvement was related to the ability to work (which we defined for childhood cases as meaning the medical improvement resulted in an increase in ability to function independently, appropriately, and effectively in an age-appropriate manner.) However, the MIRS as revised by Public Law 104–193 contains no provision for a ''related to the ability to work'' step for children and, thus, limits the application of this provision to individuals age 18 or over. Accordingly, we have deleted that step from our rules (paragraph (d) of our prior rules).

If there has been medical improvement, the next step under these

rules (discussed in detail in paragraph (b)(2)) is to consider whether the impairment(s) that we considered at the time of our most recent favorable determination or decision still meets, or is still equivalent in severity to, the listing that it met or was equivalent in severity to at that time, as that listing then appeared, even if that listing has since been revised or removed from the Listing. If that impairment(s) would still meet or equal in severity that listing, we will find the child still disabled, subject to certain exceptions discussed in paragraphs (e) and (f) of this section and discussed below.

If that impairment(s) would not now meet or equal in severity that listing, we will then consider whether the child is currently disabled, taking into account all current impairments, including any the child did not have or that we did not consider at the time of our most recent favorable determination or decision.

At this step (discussed in detail in paragraph (b)(3)), we first consider whether the child has a severe impairment or combination of impairments considering all current impairments. If the child does not, we will find the child not disabled. If so, we then consider whether the child's current impairment(s) meets, or is medically equivalent or functionally equivalent in severity to, any listing in the Listing of Impairments. If so, the child continues to be disabled; if not, the child is not disabled.

We will not always follow these steps in order. In final paragraph (b), we added language explaining that we may skip steps in the sequence if it is clear this would lead to a more prompt finding that disability continues. We will not skip any steps unless it is clear that a continuance will result. For example, we might not consider the issue of medical improvement if it is obvious on the face of the evidence that a current impairment meets the severity of a listed impairment.

Final paragraph (c) discussed what we mean by ''medical improvement''; i.e., any decrease in the severity of the medical impairment(s) which was present at the time of our most recent favorable determination or decision. This paragraph is largely the same under our prior rules, but we have added language to make it clear that we will disregard minor changes in the individual's signs, symptoms, and laboratory findings that obviously do not represent medical improvement and could not result in a finding that the individual's disability has ended. This is a longstanding procedure we have used in cases in which there is technically medical improvement because there is some very slight improvement in a sign, symptom, or laboratory finding (e.g., a change in IQ from 61 to 62) but it is clear that the outcome will not change.

Final paragraph (d), largely unchanged from prior paragraph (e), explains what we will do if we cannot find the prior file. First, we will determine whether the child is currently disabled. If not, we will decide whether to attempt reconstruction of those portions of the missing file that were relevant to our most recent favorable determination or decision, so as to allow a decision whether there has been medical improvement since that time. If we do not or cannot reconstruct the file, we will not find medical improvement.

Paragraph (e) concerns ''the first group of exceptions to medical improvement.'' The law provides limited situations in which disability can be found to have ended even though medical improvement has not occurred, if the child's impairment(s) no longer results in marked and severe functional limitations. Two of the exceptions in our prior rules—the ''advances in medical or vocational therapy or technology'' exception and the ''vocational therapy'' exception—have been limited by Public Law 104–193 to individuals who have attained age 18. The third exception is still applicable: A child's disability may be found to have ceased if substantial evidence shows that, based on new or improved diagnostic techniques or evaluations, the child's impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable determination or decision. We have revised this exception to conform to the new definition of disability for children.

Final paragraph (f), largely unchanged from prior paragraph (g), concerns ''the second group of exceptions to medical improvement.'' These exceptions include such issues as fraud and failure to cooperate in obtaining evidence. If one of these exceptions applies, we may find that disability ceases without finding medical improvement or that the child is currently disabled. We have revised the language concerning these exceptions to conform to the new definition of disability for children.

Final paragraph (g) (prior paragraph (h)) concerns the month we will find a child no longer disabled. We revised the language slightly to conform to the new definition of disability for children.

Final paragraph (h) (prior paragraph, (i)) provides that, before we stop benefits, we will provide an opportunity for an appeal, and gives a reference to the rules on appeals; it is unchanged from our prior rules.

Final paragraph (i) is new; it implements provisions in Public Law 104–193 requiring that, if a child has a representative payee, that payee must present evidence at the time of a CDR showing that the child is and has been receiving treatment to the extent considered medically necessary and available for the condition(s) that was the basis for providing SSI benefits, unless we determine such evidence would be inappropriate or unnecessary, considering the nature of the child's impairment(s). If the payee refuses without good cause to provide evidence, and it is in the best interests of the child, we will determine if another payee should be selected or if the child should receive benefits directly.

In paragraph (i)(1), we explain that ''medically necessary'' treatment means treatment that is expected to improve or restore the individual's functioning and that was prescribed by a ''treating source'' as defined in § 416.902. If the child does not have a treating source, we will decide whether there is medically necessary treatment that could have been prescribed by a treating source. In paragraph (i)(2), we list some factors we will consider in evaluating whether medically necessary treatment is available; e.g., the location of institutions or facilities that could provide treatment, the availability and cost of transportation to such places, the availability of local community resources that would provide free treatment.

In paragraph (i)(3), we explain that we will not require a payee to show proof of treatment if we decide that the disabling impairment(s) is not amenable to treatment. In paragraph (i)(4), we explain that if the representative payee refuses without good cause to provide evidence of treatment, we will, if it is in the child's best interests, remove the payee and determine if another payee should be selected or if the child should receive benefits directly. We further explain that when we consider whether a representative payee had good cause, we will consider factors such as the acceptable reasons for failure to follow prescribed treatment in § 416.930(c) and other factors similar to those describing good cause for missing deadlines in § 416.1411.

Finally, in paragraph (i)(5) we explain that the requirements of paragraph (i) do not apply to a child who is receiving SSI payments directly. This is because the treatment provision in Public Law 104–193 applies only to children who have representative payees. However, we have also included a reminder that the failure-to-follow-prescribed-treatment rules in § 416.930 continue to apply to

children who do not have representative payees.

Other Changes

Sections that have been changed only so that their language will conform to the new definition of disability for children, or to provide references to new or revised rules, include listings sections 103.00, 104.00, 112.00, and 114.00, and §§ 416.901, 416.912, 416.913, and 416.919a.

Electronic Version

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Regulatory Procedures

Pursuant to section 702(a)(5) of the Act, 42 U.S.C. 902(a)(5), the Social Security Administration follows the Administrative Procedure Act (APA) rulemaking procedures specified in 5 U.S.C. 553 in the development of its regulations. The APA provides exceptions to its Notice of Proposed Rulemaking (NPRM) procedures when an agency finds that there is good cause for dispensing with such procedures on the basis that they are impracticable, unnecessary, or contrary to the public interest. In the case of these interim final rules, we have determined that under 5 U.S.C. 553(b)(B), good cause exists for waiving the NPRM procedures.

Public Law 104–193 was signed into law on August 22, 1996. Sections 211 and 212 of the law were effective upon enactment (or with respect to benefits for months beginning on or after enactment) without regard to whether regulations have been issued. In addition, section 215 requires the Commissioner to issue regulations necessary to carry out the amendments made by sections 211 and 212, which are the subject of these interim final rules, within 3 months after the date of enactment. Accordingly, to issue these rules as an NPRM would have delayed issuance of final rules until well past 3 months after enactment.

In light of the Congressional mandate that we issue regulations needed to carry out these statutory provisions as expeditiously as possible (see H.R. Rep. No. 651, 104th Cong., 2d Sess. 1392 (1996), *reprinted in* 1996 U.S. Code, Cong. and Ad. News 2183, 2451), we believe good cause exists for waiver of the NPRM procedures under the APA since issuance of proposed rules would be impracticable and contrary to Congressional intent. In light of the short statutory deadline in which to prescribe regulations under section 215 of Public Law 104–193, we find that use of the NPRM process is impracticable. Moreover, some of the changes in these rules are technical ones to conform our rules to the new definition of disability for children. The technical changes made by these rules are minor and do not represent discretionary policy. Accordingly, we find that prior notice and comment are unnecessary with respect to these rules. However, even though we are issuing these rules as interim final regulations, we are requesting public comments and will issue revised rules if necessary.

Executive Order 12866

These interim final rules reflect and implement the disability provisions of sections 211 and 212 of Public law 104–193. This is a major rule as defined in section 251 of Public Law 104–121, 5 U.S.C. 804. The Office of Management and Budget (OMB) has reviewed these interim final rules and determined that they meet the criteria for a significant regulatory action under Executive Order 12866. Therefore, we prepared and submitted to OMB, separately from these interim final rules, an assessment of the potential costs and benefits of this regulatory action. This assessment is available for review by members of the public.

The potential costs and benefits for the policies reflected in these interim final rules follow:

Program Savings

It is estimated that due to the legislation there would be reduced program outlays resulting in the following savings (in millions of dollars) to the SSI program (over $4.7 billion total in a 6-year period):

FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	Total
−$120	−$715	−$945	−$1,075	−$905	−$1,010	−$4,775

This is the amount we expect to spend (in millions of dollars) on SSI childhood disability benefits:

FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	Total
$5,425	$5,285	$5,475	$6,300	$5,715	$6,505	$34,705

Note: Annual numbers may not add to total due to rounding.

It is also estimated that there will be reduced Medicaid program outlays (Federal share) resulting in the following savings (in millions of dollars) over a 6-year period:

FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	Total
−10	−85	−110	−125	−125	−135	−590

There will also be reduced Medicaid program outlays for States.

Administrative Costs and Savings

The administrative cost of conducting the medical redeterminations of the children who might be affected by the new childhood disability standards is expected to be $185 million in FY 1997 and $130 million in FY 1998. For this regulation, the administrative cost of redetermining disability in SSI childhood recipients is assumed to be same as the cost of a full medical CDR for these individuals, including the additional appellate costs.

From FYs 1999–2002, the ongoing Federal workyear savings are from fewer recipients on the rolls, i.e., from those children currently receiving benefits who will be terminated and from those children who will be denied under the

stricter standards. There will be net savings of approximately $12 million annually beginning with FY99. These savings will result from fewer income and resource redeterminations, representative payee actions, and maintenance of the rolls activities. The ongoing State workyear costs are for additional hearings, as well as medical reviews from additional reconsiderations, resulting from the stricter childhood disability standard.

Estimated administrative costs ($ in millions, rounded to the nearest $5 million) and workyears (rounded to the nearest 50) are:

	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	Total
	$185	$130	−$10	−$10	−$10	−$10	$265
	Workyears						
Federal	900	650	−250	−250	−250	−250	550
State	1,200	1,250	150	150	150	150	3,050
Total	2,100	1,900	−100	−100	−100	−100	3,550

Note: Annual numbers may not add to total due to rounding.

Reductions in SSI Recipients (in thousands):

We expect benefit eligibility for a total of 135,000 of those children receiving benefits at date of enactment will be terminated as a result of these changes in the law. The following figures show the estimated annual effect of the legislation on projected numbers of recipients of Federal SSI benefits:

	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002
Current recipients	−10	−95	−110	−95	−80	−70
New awards	−10	−35	−50	−70	−80	−90
Total	−20	−130	−160	−165	−160	−160

With the reductions in SSI recipients shown above, we estimate the average number of disabled children (in thousands) in payment status after implementation of these interim final rules will be:

FY1997	FY1998	FY1999	FY2000	FY2001	FY2002
1,010	950	955	990	1,015	1,040

Note: Annual numbers may not add to total due to rounding.

Regulatory Flexibility Act

We certify that these interim final rules will not have a significant economic impact on a substantial number of small entities since this rule affects only individuals. Therefore, a regulatory flexibility analysis as provided in Public Law 96–354, the Regulatory Flexibility Act, as amended by Public Law 104–121 is not required.

Paperwork Reduction Act

These interim final rules contain a new information collection requirement in Part 416, section 416.924(g). As required by 44 U.S.C. 3507, as amended by section 2 of the Paperwork Reduction Act of 1995, we have requested under emergency procedures, and OMB has approved, under OMB #0960–0568, the information collection requirements contained in section 416.924(g).

(Catalog of Federal Domestic Assistance: Program Nos. 96.001 Social Security-Disability Insurance; 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, Aged, Blind, Disability benefits, Public assistance programs, Reporting and recordkeeping requirements, Supplemental Security Income (SSI).

Dated: February 5, 1997.

Shirley S. Chater,

Commissioner of Social Security.

For the reasons set out in the preamble, 20 CFR chapter III is amended as follows:

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

Subpart P—[Amended]

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

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

Appendix 1 to Subpart P—[Amended]

2. Part B of Appendix 1 (Listing of Impairments) of subpart P to part 404 is amended by revising the third sentence of the second undesignated paragraph of 103.00A, the fourth undesignated paragraph of 103.00A, the fourth sentence of the fifth undesignated paragraph of 104.00A, the sixth undesignated paragraph of 104.00A, the last sentence of the last undesignated paragraph of 104.00C, the first three sentences of the eighth undesignated paragraph of 112.00A, the third sentence of the first paragraph of

112.00C, the first sentence of 112.00C2. introductory text 112.00C2.b., 112.00C2.c., the heading of 112.00C2.d., 112.00C4 and the undesignated paragraph under it, and 112.02B2.c. introductory text to read as follows:

Appendix 1 to Subpart P—Listing of Impairments

* * * * *

Part B

* * * * *

103.00 Respiratory System

A. * * *

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* * * Even if a child does not show that his or her impairment meets the criteria of these listings, the child may have an impairment(s) that is medically or functionally equivalent in severity to one of the listed impairments. * * *

* * * * *

It must be remembered that these listings are only examples of common respiratory disorders that are severe enough to find a child disabled. When a child has a medically determinable impairment that is not listed, an impairment that does not meet the requirements of a listing, or a combination of impairments no one of which meets the requirements of a listing, we will make a determination whether the child's impairment(s) is medically or functionally equivalent in severity to the criteria of a listing. (See §§ 404.1526, 416.926, and 416.926a.)

* * * * *

104.00 Cardiovascular System

A. Introduction

* * * * *

* * * Even though a child who does not receive treatment may not be able to show an impairment that meets the criteria of these listings, the child may have an impairment(s) that is medically or functionally equivalent in severity to one of the listed impairments.

Indeed, it must be remembered that these listings are only examples of common cardiovascular disorders that are severe enough to find a child disabled. When a child has a medically determinable impairment that is not listed, an impairment that does not meet the requirements of a listing, or a combination of impairments no one of which meets the requirements of a listing, we will make a determination whether the child's impairment(s) is medically or functionally equivalent in severity to the criteria of a listing. (See §§ 404.1526, 416.926, and 416.926a.)

* * * * *

C. Treatment and Relationship Status

* * * * *

* * * (See § 404.1594 or § 416.994a, as appropriate, for our rules on medical improvement and whether an individual is no longer disabled.)

112.00 Mental Disorders

A. * * *

* * * * *

It must be remembered that these listings are only examples of common mental disorders that are severe enough to find a child disabled. When a child has a medically determinable impairment that is not listed, an impairment that does not meet the requirements of a listing, or a combination of impairments no one of which meets the requirements of a listing, we will make a determination whether the child's impairment(s) is medically or functionally equivalent in severity to the criteria of a listing. (See §§ 404.1526, 416.926, and 416.926a.)

* * *

* * * * *

C. * * * The functional areas that we consider are: Motor function; cognitive/communicative function; social function; personal function; and concentration, persistence, or pace.

* * *

1. * * *

2. *Preschool children (age 3 to attainment of age 6).* For the age groups including preschool children through adolescence, the functional areas used to measure severity are: (a) Cognitive/communicative function, (b) social function, (c) personal function, and (d) deficiencies of concentration, persistence, or pace resulting in frequent failure to complete tasks in a timely manner. * * *

a. * * *

b. *Social function.* Social functioning refers to a child's capacity to form and maintain relationships with parents, other adults, and peers. Social functioning includes the ability to get along with others (e.g., family members, neighborhood friends, classmates, teachers). Impaired social functioning may be caused by inappropriate externalized actions (e.g., running away, physical aggression—but not self-injurious actions, which are evaluated in the personal area of functioning), or inappropriate internalized actions (e.g., social isolation, avoidance of interpersonal activities, mutism). Its severity must be documented in terms of intensity, frequency, and duration, and shown to be beyond what might be reasonably expected for age. Strength in social functioning may be documented by such things as the child's ability to respond to and initiate social interaction with others, to sustain relationships, and to participate in group activities. Cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity, appropriate to a child's age, also need to be considered. Social functioning in play and school may involve interactions with adults, including responding appropriately to persons in authority (e.g., teachers, coaches) or cooperative behaviors involving other children. Social functioning is observed not only at home but also in preschool programs.

c. *Personal function.* Personal functioning in preschool children pertains to self-care; i.e., personal needs, health, and safety (feeding, dressing, toileting, bathing; maintaining personal hygiene, proper nutrition, sleep, health habits; adhering to medication or therapy regimens; following safety precautions). Development of self-care skills is measured in terms of the child's increasing ability to help himself/herself and to cooperate with others in taking care of these needs. Impaired ability in this area is manifested by failure to develop such skills, failure to use them, or self-injurious actions. This function may be documented by a standardized test of adaptive behavior or by a careful description of the full range of self-care activities. These activities are often observed not only at home but also in preschool programs.

d. *Concentration, persistence, or pace.*

* * *

* * * * *

4. *Adolescents (age 12 to attainment of age 18).* Functional criteria parallel to those for primary school children (cognitive/communicative; social; personal; and concentration, persistence, or pace) are the measure of severity for this age group. Testing instruments appropriate to adolescents should be used where indicated. Comparable findings of disruption of social function must consider the capacity to form appropriate, stable, and lasting relationships. If information is available about cooperative working relationships in school or at part-time or full-time work, or about the ability to work as a member of a group, it should be considered when assessing the child's social functioning. Markedly impoverished social contact, isolation, withdrawal, and inappropriate or bizarre behavior under the stress of socializing with others also constitute comparable findings. (Note that self-injurious actions are evaluated in the personal area of functioning.)

a. Personal functioning in adolescents pertains to self-care. It is measured in

the same terms as for younger children, the focus, however, being on the adolescent's ability to take care of his or her own personal needs, health, and safety without assistance. Impaired ability in this area is manifested by failure to take care of these needs or by self-injurious actions. This function may be documented by a standardized test of adaptive behavior or by careful descriptions of the full range of self-care activities.

b. In adolescents, the intent of the functional criterion described in paragraph B2d is the same as in primary school children, However, other evidence of this functional impairment may also be available, such as from evidence of the child's performance in wok or work-like settings.

* * * * *

112.01 Category of Impairments, Mental

112.02 Organic Mental Disorders:

* * * * *

B. * * *

* * * * *

2. * * *

c. Marked impairment in age-appropriate personal functioning, documented by history and medical findings (including consideration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, appropriate standardized tests; or

* * * * *

3. Part B of Appendix 1 (Listing of Impairments) of subpart P to part 404 is amended by revising 114.00D6 and removing the last sentence of the second undesignated paragraph under 114.00D6.

114.00 Immune System

* * * * *

D. * * *

6. Evaluation of HIV infection in children. The criteria in 114.08 do not describe the full spectrum of diseases or conditions manifested by children with HIV infection. As in any case, consideration must be given to whether a child's impairment(s) meets, medically equals, or functionally equals the severity of any other listing in appendix 1 of subpart P; e.g., a neoplastic disorder listed in 113.00ff. (See §§ 404.1526, 416.926, and 416.926a.) Although 114.08 includes cross-references to other listings for the more common manifestations of HIV infection, additional listings may also apply.

* * * * *

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

Subpart F—[Amended]

4. The authority citation for subpart F of part 416 continues to read as follows:

Authority: Secs. 702(a)(5), 1631(a)(2) and (d)(1) of the Social Security Act (42 U.S.C. 902(a)(5) and 1383(a)(2) and (d)(1)).

5. Section 416.635 is amended by revising paragraphs (c) and (d) and adding paragraph (e) to read as follows:

§ 416.635 Responsibilities of a representative payee.

* * * * *

(c) Submit to us, upon our request, a written report accounting for the benefits received;

(d) Notify us of any change in his or her circumstances that would affect performance of the payee responsibilities; and

(e) In cases in which the beneficiary is an individual under age 18 (including cases in which the beneficiary is an individual whose low birth weight is a contributing factor material to our determination that the individual is disabled), ensure that the beneficiary is and has been receiving treatment to the extent considered medically necessary and available for the condition that was the basis for providing benefits (See § 416.994a(i).)

Subpart I—[Amended]

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

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

7. Section 416.901 is amended by revising paragraphs (e), (f)(2), and (f)(6) as follows:

§ 416.901 Scope of subpart.

* * * * *

(e) Our general rules on evaluating disability for children filing new applications are stated in § 416.924.

(f) * * *

* * * * *

(2) What we mean by the terms *medical equivalence* and *functional equivalence* and how we determine medical equivalence (and functional equivalence if you are a child);

* * * * *

(6) The effect on your benefits if you fail to follow treatment that is expected to restore your ability to work or, if you are a child, to reduce your functional limitations to the point that they are no longer marked and severe, and how we apply the rule in § 416.930.

* * * * *

7. Section 416.902 is amended by adding four new definitions between the definitions for ''Child'' and ''Medical sources'' to read as follows:

§ 416.902 General definitions and terms for this subpart.

* * * * *

Commissioner means the Commissioner of Social Security.

Disability redetermination means a redetermination of your eligibility based on disability using the rules for new applicants appropriate to your age, except the rules pertaining to performance of substantial gainful activity. For individuals who are working and for whom a disability redetermination is required, we will apply the rules in §§ 416.260 ff. In conducting a disability redetermination, we will not use the rules for determining whether disability continues set forth in § 416.994 or § 416.994a. (See § 416.987.)

Impairment(s) means a medically determinable physical or mental impairment or a combination of medically determinable physical or mental impairments.

Marked and severe functional limitations, when used as a phrase, means the standard of disability in the Social Security Act for children claiming SSI benefits based on disability and is a level of severity that meets or medically or functionally equals the severity of a listing in the Listing of Impairments in appendix 1 of subpart P of part 404 (the Listing). See §§ 416.906, 416.924, and 416.926a. The words ''marked'' and ''severe'' are also separate terms used throughout this subpart to describe measures of functional limitations; the term ''marked'' is also used in the listings. See §§ 416.924 and 416.926a. The meaning of the words ''marked'' and ''severe'' when used as part of the term *Marked and severe functional limitations* is not the same as the meaning of the separate terms *''marked'' and ''severe'' used elsewhere in 20 CFR 404 and 416. (See §§ 416.924(c) and 416.926a(c).)*

* * * * *

8. Section 416.906 is revised to read as follows:

§ 416.906 Basic definition of disability for children.

If you are under age 18, we will consider you disabled if you have a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months. Notwithstanding the preceding sentence, if you file a new application for benefits and you are engaging in substantial gainful activity, we will not consider you disabled. We discuss our rules for determining disability in children who file new applications in §§ 416.924 through 416.924c and §§ 416.925 through 416.926a.

9. Section 416.911 is revised to read as follows:

§ 416.911 Definition of disabling impairment.

(a) If you are an adult:

(1) A disabling impairment is an impairment (or combination of impairments) which, of itself, is so severe that it meets or equals a set of criteria in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter or which, when considered with your age, education and work experience, would result in a finding that you are disabled under § 416.994, unless the disability redetermination rules in § 416.987(b) apply to you.

(2) If the disability redetermination rules in § 416.987 apply to you, a disabling impairment is an impairment or combination of impairments that meets the requirements in §§ 416.920(c) through (f).

(b) If you are a child, a disabling impairment is an impairment (or combination of impairments) that causes marked and severe functional limitations. This means that the impairment or combination of impairments:

(1) Must meet or medically or functionally equal the requirements of a listing in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter, or

(2) Would result in a finding that you are disabled under § 416.994a.

(c) In determining whether you have a disabling impairment, earnings are not considered.

10. Section 416.912 is amended by revising paragraphs (a) and (c)(6) to read as follows:

§ 416.912 Evidence of your impairment.

(a) *General.* In general, you have to prove to us that you are blind or disabled. This means that you must furnish medical and other evidence that we can use to reach conclusions about your medical impairment(s). If material to the determination whether you are blind or disabled, medical and other evidence must be furnished about the effects of your impairment(s) on your ability to work, or if you are a child, on your functioning, on a sustained basis. We will consider only impairment(s) you say you have or about which we receive evidence.

* * * * *

(c) * * *

(6) Any other factors showing how your impairment(s) affects your ability to work, or, if you are a child, your functioning. In §§ 416.960 through 416.969, we discuss in more detail the evidence we need when we consider vocational factors.

* * * * *

11. Section 416.913 is amended by revising paragraph (c)(3) to read as follows:

§ 416.913 Medical evidence of your impairment.

* * * * *

(c) * * *

(3) If you are a child, the medical source's opinion about your functional limitations in learning, motor functioning, performing self-care activities, communicating, socializing, and completing tasks (and, if you are a newborn or young infant from birth to age 1, responsiveness to stimuli).

* * * * *

12. Section 416.919a is amended by revising paragraph (b)(5) to read as follows:

§ 416.919a When we will purchase a consultative examination and how we will use it.

* * * * *

(b) * * *

(5) There is an indication of a change in your condition that is likely to affect your ability to work, or, if you are a child, your functioning, but the current severity of your impairment is not established.

13. Section 416.919n is amended by revising the fifth sentence of paragraph (b) and paragraph (c)(6) to read as follows:

§ 416.919n Informing the examining physician or psychologist of examination scheduling, report content, and signature requirements.

* * * * *

(b) * * * The medical report must be complete enough to help us determine the nature, severity, and duration of the impairment, and your residual functional capacity (if you are an adult) or your functioning (if you are a child). * * *

(c) * * *

(6) A statement about what you can still d0 despite your impairment(s), unless the claim is based on statutory blindness. If you are an adult, this statement should describe the opinion of the consultative physician or psychologist about your ability, despite your impairment(s), to do work-related activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling; and, in cases of mental impairment(s), the opinion of the consultative physician or psychologist about your ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers and work pressures in a work setting. If you are a child, this statement should describe the opinion of the consultative physician or psychologist about your functional limitations in learning, motor functioning, performing self-care activities, communicating, socializing, and completing tasks (and, if you are a newborn or young infant from birth to age 1, responsiveness to stimuli); and

* * * * *

14. Section 416.924 is amended by removing paragraphs (a) and (f), redesignating paragraphs (b) through (e) as (a) through (d), adding new paragraphs (e) and (g), redesignating prior paragraph (g) as paragraph (f), and by revising newly designated paragraphs (a), (c), and (d) to read as follows:

§ 416.924 How we determine disability for children.

(a) *Steps in evaluating disability.* We consider all relevant evidence in your case record when we make a determination or decision whether you are disabled. If you allege more than one impairment, we will evaluate all the impairments for which we have evidence. Thus, we will consider the combined effects of all your impairments upon your overall health and functioning. We will also evaluate any limitations in your functioning that result from your symptoms, including pain (see § 416.929). When you file a new application for benefits, we use the evaluation process set forth in (b) through (d) of this section. We follow a set order to determine whether you are disabled. If you are doing substantial gainful activity, we will determine that you are not disabled and not review your claim further. If you are not doing substantial gainful activity, we will consider your physical or mental impairment(s) first to see if you have an impairment or combination of

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

* * * * *

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

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

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

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

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

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

* * * * *

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

15. Section 416.924a is amended by removing paragraph (a)(4), redesignating paragraph (a)(5) as paragraph (a)(4), removing paragraph (b), redesignating paragraphs (c) and (d) as paragraphs (b) and (c), revising the third sentence of paragraph (a) introductory text, revising paragraph (a)(2), revising the first sentence of paragraph (a)(3), revising the first sentence of redesignated paragraph (b) introductory text, and revising redesignated paragraphs (c)(1) and (c)(4) to read as follows:

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

(a) * * * However, your age is always an important factor when we decide whether your impairment(s) is severe (see § 416.924(c)). * * *

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

(3) When we compare an unlisted impairment with a listed impairment to determine whether you have an impairment(s) that medically or functionally equals the severity of a listing, the way in which we consider your age will depend on the listing we use for comparison. * * *

(b) *Correcting chronological age of premature infants.* We generally use chronological age (that is, a child's age based on birth date) when we decide whether, or the extent to which, a physical or mental impairment or combination of impairments causes functional limitations. * * *

* * * * *

(c) * * *

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

* * * * *

(4) As children approach adulthood—that is, by about age 16—the functional abilities, skills, and behaviors that are appropriate for them are those that are also appropriate for adults. Older adolescents generally also share with the youngest adults the same abilities to adapt to work-related activities despite a severe impairment(s). By the age of adolescence, children have developed basic physical skills and behaviors, so that impairments occurring in adolescence may not have the cumulative interactive effects on functioning that impairments occurring in infancy and early childhood do. (However, as set forth in paragraph (c)(1) of this section, we also recognize that adolescents may experience a variety of impairments with different effects on their functioning. For instance, a child born with a degenerative disorder will experience a worsening of its effects as he or she grows older so that functioning may be more limited for the older child than it is for a younger child with the same illness or disorder.)

16. Section 416.924b is amended by revising paragraph (a), the second sentences in paragraphs (b)(2) and (b)(3), and paragraph (b)(4), and by removing paragraph (b)(5) to read as follows:

§ 416.924b Functioning in children.

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

(b) * * *

(2) * * * Ordinarily, failures to achieve developmental milestones are most important as indicators of impaired functioning from birth until the attainment of age 3, although they may be used to evaluate older children, especially preschool children.

(3) * * * Ordinarily, activities of daily living are most important as indicators of functional limitations in children aged 3 to attainment of age 16, although they may be used to evaluate children younger than age 3.

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

17. Section 416.924c is revised to read:

§ 416.924c Other factors we will consider.

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

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

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

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

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

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

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

(2) The fact that you are able to attend school will not, in itself, be an indication that you are not disabled. We will consider the circumstances of your school attendance, such as your functioning in a regular classroom

setting. Likewise, the fact that you are in a special education classroom setting, or that you are not in such a setting, will not in itself establish your actual limitations or abilities. We will consider the fact of such placement or lack of placement in the context of the remainder of the evidence in your case record.

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

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

18. Section 416.924d is removed.

19. Section 416.924e is removed.

20. Section 416.925 is amended by revising paragraph (a) and adding five sentences to the end of paragraph (b)(2) to read as follows:

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

(a) *Purpose of the Listing of Impairments.* The Listing of Impairments describes, for each of the major body systems, impairments that are considered severe enough to prevent an adult from doing any gainful activity or, for a child, that causes marked and severe functional limitations. Most of the listed impairments are permanent or expected to result in death, or a specific statement of duration is made. For all others, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months.

(b) * * *

(2) * * * Although the severity criteria in Part B of the Listing of Impairments are expressed in different ways for different impairments, the level of severity for impairments listed in part B is intended to be the same as that expressed in the functional severity criteria of the childhood mental disorders listings. (See listings 112.01 ff. of appendix 1 of subpart P of part 404 of this chapter.) Therefore, in general, a child's impairment(s) is of ''listing-level severity'' if it causes marked limitations in two broad areas of functioning or extreme limitations in one such area. (See § 416.926a for definition of the terms *marked* and *extreme* as they apply to children.) However, when we decide whether your impairment(s) meets the requirements for any listed impairment, we will decide that your impairment is of ''listing-level severity'' even if it does not result in marked limitations in two broad areas of functioning, or extreme limitations in one such area, if the listing that we apply does not require such limitations to establish that an impairment(s) is disabling.

* * * * *

21. Section 416.926 is amended by revising the section heading, paragraph (a), the last sentence of paragraph (b), and the first sentence of paragraph (c), and by adding paragraph (d) to read as follows:

§ 416.926 Medical equivalence for adults and children.

(a) *How medical equivalence is determined.* We will decide that your impairment(s) is medically equivalent to a listed impairment in appendix 1 of subpart P of part 404 of this chapter if the medical findings are at least equal in severity and duration to the listed findings. We will compare the symptoms, signs, and laboratory findings about your impairment(s), as shown in the medical evidence we have about your claim, with the corresponding medical criteria shown for any listed impairment. When we make a finding regarding medical equivalence, we will consider all relevant evidence in your case record. Medical equivalence can be found in two ways:

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

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

(ii) You exhibit all of the medical findings, but one or more of the findings is not as severe as specified in the listing, we will nevertheless find that your impairment is medically equivalent to that listing if you have other medical findings related to your impairment that are at least of equal medical significance.

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

(b) * * * We will also consider the medical opinion given by one or more medical or psychological consultants designated by the Commissioner in deciding medical equivalence. (See § 416.1016.)

(c) *Who is a designated medical or psychological consultant.* A medical or psychological consultant designated by the Commissioner includes any medical or psychological consultant employed or engaged to make medical judgments by the Social Security Administration, the Railroad Retirement Board, or a State agency authorized to make disability determinations. * * *

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

22. Section 416.926a is revised to read as follows:

§ 416.926a Functional equivalence for children

(a) *General.* If your impairment or combination of impairments does not meet, or is not medically equivalent in severity to, any listed impairment in appendix 1 of subpart P of part 404 of this chapter, we will assess all functional limitations caused by your impairment(s), i.e., what you cannot do because of your impairment(s), to determine if your impairment(s) is functionally equivalent in severity to any listed impairment. While all possible impairments are not addressed within the Listing of Impairments, within the listed impairments are all the

physical and mental functional limitations, i.e., what a child cannot do as a result of an impairment, that produce marked and severe functional limitations. If the functional limitation(s) caused by your impairment(s) is the same as the disabling functional limitation(s) caused by a listed impairment, we will find that your impairment(s) is equivalent in severity to that listed impairment, even if your impairment(s) is not medically related to the listed impairment. When we make a determination or decision using this rule, the primary focus will be on whether your functional limitations are disabling, as long as there is a direct, medically determinable cause for these limitations. As with any disabling impairment, the duration requirement must also be met (see §§ 416.909 and 416.924(a)).

(b) *How we determine functional equivalence.* We will compare any functional limitations resulting from your impairment(s) with the disabling functional limitations of any listed impairment in part A or part B of the Listing that includes the same functional limitations. The listing we use for comparison need not be medically related to your impairment(s). In paragraphs (b)(1) through (b)(4) of this section we explain the methods we may use to decide that your impairment(s) is functionally equivalent in severity to a listing. There is no set order in which we must consider these methods and we may not consider them all if we find that your impairment(s) is functionally equivalent in severity to a listed impairment. We will use any method that is appropriate to, or best describes, your impairment(s) and functional limitations. However, we will consider all of the methods before we determine that your impairment(s) is *not* functionally equivalent in severity to any listed impairment. At the initial and reconsideration levels (except when a disability hearing officer makes the reconsideration determination), we will also complete a standard form, Form SSA–538, Childhood Disability Evaluation Form, to show how we determined whether your impairment(s) is functionally equivalent in severity to a listed impairment. (See § 416.924(g).)

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

(2) *Broad areas of development or functioning.* Instead of looking at limitation of specific functions, we may evaluate the effects of your impairment(s) in broad areas of development or functioning, such as social functioning, motor functioning, or personal functioning (i.e., self-care) and determine if your functional limitations are equivalent in severity to the disabling functional limitations in listing 112.12 or listing 112.02. If you have extreme limitations in one area of functioning or marked limitation in two areas of functioning, we will find that your impairment(s) is functionally equivalent in severity to a listed impairment. We explain the broad areas of development or functioning we consider and what the terms ''extreme'' and ''marked'' mean in paragraph (c) of this section.

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

(4) *Limitations related to treatment or medication effects.* Some impairments require treatment over a long period of time (i.e., at least a year) and the treatment itself (e.g., multiple surgeries) causes marked and severe functional limitations. Marked and severe functional limitations may also result from the combined effects of limitations caused by ongoing treatment and limitations caused by an impairment(s). In many cases, we will be able to evaluate such limitations using the methods for evaluating specific functions or broad areas of development or functioning in paragraphs (b)(1) and (b)(2) of this section. But we may also compare your functional limitations(s) to criteria in listings based on treatment (including side effects of medication) that is itself disabling or that contributes to functional limitations. If treatment of your impairment(s) produces functional limitations that are the same as the disabling functional limitations of a listed impairment, we will find that your impairment(s) is functionally equivalent in severity to that listing.

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

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

(ii) In some children, some physical impairments will be evaluated most

appropriately only in the areas of motor development or motor functioning. In others, the effects will be more global. If you have a physical impairment(s) that causes a functional limitation(s) not addressed solely in the area of motor development or motor functioning, we will consider the effects of your impairment in all relevant areas in which you have limitations from the impairment(s). A physical impairment(s) may cause limitations in any or all of the areas of development or functioning.

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

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

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

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

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

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

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

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

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

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

(iii) *Social:* The ability or inability to form and maintain relationships with other individuals and with groups; e.g., parents, siblings, neighborhood children, classmates, teachers. Ability is manifested in responding to and initiating social interaction with others, sustaining relationships, and participating in group activities. It involves cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity appropriate to a child's age. Ability is also manifested in the absence of inappropriate externalized actions (e.g., running away, physical aggression—but not self-injurious actions, which are evaluated in the personal area of functioning), and the absence of inappropriate internalized actions (e.g., social isolation, avoidance of interpersonal activities, mutism). Social functioning in play, school, and work situations may involve interactions with adults, including responding appropriately to persons in authority (e.g., teachers, coaches, employers) or cooperative behaviors involving other children.

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

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

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

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

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

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

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

emotional cues (e.g., facial expressions, vocal tone changes).

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

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

(A) *Cognitive/communicative development (age 1 to attainment of age 3):* Your ability or inability to understand by responding to increasingly complex requests, instructions, and questions; to refer to yourself and things around you by pointing and eventually by naming; to form concepts and to solve simple problems through purposeful experimentation (e.g., disassembling toys), imitation (immediate and delayed), and constructive play (e.g., putting things in and out of containers, building with blocks, exploring spaces); to demonstrate your knowledge of objects, actions, and situations you have encountered through pretend play activities; to spontaneously communicate your wishes or needs by using gestures, an increasing number of intelligible words, and eventually grammatically correct simple sentences and questions with increasingly rich and broad vocabulary.

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

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

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

(A) *Cognitive/communicative development (age 3 to attainment of age 6):* Your ability or inability to learn, understand, and solve problems through intuition, perception, verbal and nonverbal reasoning, and the application of acquired knowledge; your ability or inability to retain and recall information, images, events, and procedures during the process of thinking (as in the development of readiness skills for formal learning (e.g., learning letters, shapes, colors) and skills for daily living (e.g., putting toys in proper places)). Your ability or inability to communicate by expressing your needs, feelings, and preferences; by telling, requesting, predicting, and relating information; by describing actions and functions; by providing explanations; by following and giving directions; and by engaging in conversation in a spontaneous, interactive, and increasingly intelligible manner, using increasingly complex vocabulary and grammar.

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

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

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

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

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

(A) *Cognitive/communicative functioning (age 6 to attainment of age 12):* Your ability or inability to learn, understand, and solve problems through intuition, perception, verbal and nonverbal reasoning, and the application of acquired knowledge; the ability to retain and recall information, images, events, and procedures during the process of thinking, as in formal learning situations (e.g., reading, class discussions) and in daily living (e.g., telling time, making change). Your ability or inability to comprehend and produce language (e.g., vocabulary, grammar) in order to communicate in social conversation (e.g., to express feelings, meet needs, seek information, describe events, share stories), and in learning situations (e.g., to exchange information and ideas with peers and family or with groups such as your school classes) in a spontaneous, interactive, sustained, and intelligible manner, using increasingly complex vocabulary and grammar.

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

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

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

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

(v) *Adolescents (age 12 to attainment of age 18):* Children in this age group are evaluated in terms of five areas of functioning. The following are general descriptions of functioning typical of this age group.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23. Section 416.927 is amended by revising paragraph (a)(1) to read as follows:

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

(a) *General.* (1) If you are an adult, you can only be found disabled if you are unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. (See § 416.905.) If you are a child, you can be found disabled only if you have a medically determinable physical or mental impairment(s) that causes marked and severe functional limitations and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. (See § 416.906.)

* * * * *

24. Section 416.929 is amended by revising the fourth, fifth, and last sentences of paragraph (a), the heading

of paragraph (c), the first and last sentences of paragraph (c)(1), the second sentence of paragraph (c)(2), the heading and the first and last sentences of paragraph (c)(4), the reference at the end of paragraph (d)(1), the sixth and ninth sentences of paragraph (d)(3), and paragraph (d)(4) to read as follows:

§ 416.929 How we evaluate symptoms, including pain.

(a) * * * These include statements or reports from you, your treating or examining physician or psychologist, and others about your medical history, diagnosis, prescribed treatment, daily activities, efforts to work, and any other evidence showing how your impairment(s) and any related symptoms affect your ability to work (or if you are a child, your functioning). We will consider all of your statements about your symptoms, such as pain, and any description you, your physician, your psychologist, or other persons may provide about how the symptoms affect your activities of daily living and your ability to work (or if you are a child, your functioning). * * * We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work (or if you are a child, your functioning).

* * * * *

(c) * * * (1) *General.* When the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain, we must then evaluate the intensity and persistence of your symptoms so that we can determine how your symptoms limit your capacity for work or, if you are a child, your functioning. * * * Paragraphs (c)(2) through (c)(4) of this section explain further how we evaluate the intensity and persistence of your symptoms and how we determine the extent to which your symptoms limit your capacity for work (or, if you are a child, your functioning) when the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain.

(2) * * * Objective medical evidence of this type is a useful indicator to assist us in making reasonable conclusions about the intensity and persistence of your symptoms and the effect those symptoms, such as pain, may have on your ability to work or, if you are a child, your functioning. * * *

* * * * *

(4) *How we determine the extent to which symptoms, such as pain, affect your capacity to perform basic work activities, or, if you are a child, your functioning).* In determining the extent to which your symptoms, such as pain, affect your capacity to perform basic work activities (or if you are a child, your functioning), we consider all of the available evidence described in paragraphs (c)(1) through (c)(3) of this section. * * * Your symptoms, including pain, will be determined to diminish your capacity for basic work activities (or, if you are a child, your functioning) to the extent that your alleged functional limitations and restrictions due to symptoms, such as pain, can reasonably be accepted as consistent with the objective medical evidence and other evidence.

(d) * * *

(1) * * * (See § 416.920(c) for adults and § 416.924(c) for children.)

* * * * *

(3) * * * (If you are a child and we cannot find equivalence based on medical evidence only, we will consider pain and other symptoms under § 416.926(a)(b)(3) in determining whether you have an impairment(s) that causes overall functional limitations that are the same as the disabling limitations of a listed impairment.) * * * If they are not, we will consider the impact of your symptoms on your residual functional capacity if you are an adult.* * *

(4) *Impact of symptoms (including pain) on residual functional capacity or, if you are a child, on your functioning.* If you have a medically determinable severe physical or mental impairment(s), but your impairment(s) does not meet or equal an impairment listed in appendix 1 of subpart P of part 404 of this chapter, we will consider the impact of your impairment(s) and any related symptoms, including pain, or your residual functional capacity, if you are an adult, or, on your functioning if you are a child. (See §§ 416.945 and 416.924a through 416.924e.)

25. Section 416.930 is amended by revising paragraph (a) to read as follows:

§ 416.930 Need to follow prescribed treatment.

(a) *What treatment you must follow.* In order to get benefits, you must follow treatment prescribed by your physician if this treatment can restore your ability to work, or, if you are a child, if the treatment can reduce your functional limitations so that they are no longer marked and severe.

* * * * *

26. Section 416.987 and an undesignated center heading are added to 20 CFR part 416, subpart I to read as follows:

Disability Redeterminations for Individuals Who Attain Age 18

§ 416.987 Disability redeterminations for individuals who attain age 18.

(a)(1) Public Law 104–193, *The Personal Responsibility and Work Opportunity Reconciliation Act of 1996,* requires that the individuals described in paragraph (b) of this section must have their eligibility redetermined.

(2) For these individuals, subject to the provisions of paragraphs (b)(2) and (b)(3) of this section, we will use the rules for new applicants; we will not use the rules for determining whether disability continues set out in § 416.994. If you are an individual affected by the provisions of this section, we may find that you are not now disabled even though we previously found that you were disabled.

(3) Before we begin your disability redetermination, we will notify you that we are redetermining your eligibility for payments, why we are redetermining your eligibility, which disability rules we will apply, that our review could result in a finding that your SSI payments based on disability could be terminated, that you have the right to submit medical and other evidence for our consideration during the redetermination, and that when we make our determination, we will notify you of our determination, your right to appeal the determination, and your right to request continuation of benefits during appeal.

(4) We will notify you in writing of the results of the disability redetermination. The notice will tell you what our determination is, the reasons for our determination and your right to request reconsideration of the determination. If our determination shows that we should stop your SSI payments based on disability, the notice will also tell you of your right to request that your benefits continue during any appeal. The results of an initial disability redetermination are binding unless you request a reconsideration within the stated time period, or we revise the initial determination.

(b)(1) We will redetermine the eligibility of individuals

(i) Who became eligible for SSI benefits by reason of disability prior to attaining age 18, and

(ii) Who also were eligible for such benefits for the month before the month in which they attained age 18.

(2) When we make this determination, we will apply the rules in §§ 416.920(c)–(f); we will not apply the rules in § 416.920(b) or § 416.994.

(3) If you are an individual affected by the provisions of this section, and you are disabled under § 416.920 (d) or (f), and you are working, we will apply the rules in §§ 416.260 ff.

(4) We will initiate this disability redetermination during the 1-year period beginning on your 18th birthday.

(5) If we find that you are not disabled under the rules in § 416.920 (except § 416.920(b)), your eligibility will end. The month in which we will find you not disabled is explained in paragraph (b)(6) of this section; the month your benefits will stop is explained in paragraph (b)(7) of this section.

(6) If the evidence shows that you are not disabled, we will find that your disability ended in the earliest of:

(i) The month the evidence shows that you are not disabled under the rules set out in this section, but not earlier than the month in which we mail you a notice saying that you are not disabled.

(ii) The first month in which you failed without good cause to follow prescribed treatment under the rules in § 416.930.

(iii) The first month in which you failed without good cause to do what we asked. Section 416.1411 explains the factors we will consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 416.918 discusses how we determine whether you have good cause for failing to attend a consultative examination.

27. Section 416.990 is amended by revising paragraphs (b)(9) and (b)(10), adding paragraph (b)(11), and revising the first and second sentences of the definition of *Permanent impairment* in paragraph (c) to read as follows:

§ 416.990 When and how often we will conduct a continuing disability review.

* * * * *

(b) * * *

(9) Evidence we receive raises a question whether your disability or blindness continues;

(10) You have been scheduled for a vocational reexamination diary review; or

(11) By your first birthday, if you are a child whose low birth weight was a contributing factor material to our determination that you were disabled; i.e., whether we would have found you disabled if we had not considered your low birth weight.

(c) * * *

Permanent impairment—medical improvement not expected—refers to a case in which any medical improvement in a person's impairment(s) is not expected. This means an extremely severe condition determined on the basis of our experience in administering the disability programs to be at least static, but more likely to be progressively disabling either by itself or by reason of impairment complications, and unlikely to improve so as to permit the individual to engage in substantial gainful activity or, if you are a child, unlikely to improve to the point that you will no longer have marked and severe functional limitations. * * *

* * * * *

28. Section 416.994a is amended by removing paragraphs (b)(4), (b)(5), (c)(4), (d) (f)(1), and (f)(2), redesignating paragraphs (e) through (i) as paragraphs (d) through (h), redesignating paragraphs (f)(3) and (f)(4) as paragraphs (e)(1) and (e)(2), adding paragraph (i), revising the section heading and paragraphs (a)(1), revising the first sentence of the introductory text to paragraph (b), adding two sentences between the first and second sentences of the introductory text to paragraph (b), revising paragraphs (b)(1) through (b)(3), adding one sentence between the first and second sentences of the introductory text to paragraph (c), revising the third and fourth sentences of redesignated paragraph (d), revising the introductory text to redesignated paragraph (e), revising paragraph (e)(1), revising the second sentence of the introductory text to redesignated paragraph (f), and revising paragraphs (f)(4) and (g)(5) to read as follows:

§ 416.994a How we will determine whether your disability continues or ends, and whether you are and have been receiving treatment that is medically necessary and available, disabled children.

(a) * * *

(1) We will first consider whether there has been medical improvement in your impairment(s). We define ''medical improvement'' in paragraph (c) of this section. If there has been no medical improvement, we will find you are still disabled unless one of the exceptions in paragraphs (e) or (f) of this section applies. If there has been medical improvement, we will consider whether the impairments(s) you had at the time of our most recent favorable determination or decision now meets or medically or functionally equals the severity of the listing it met or equalled at that time. If so, we will find you are still disabled, unless one of the exceptions in paragraphs (e) or (f) of this section applies. If not, we will consider whether your current impairment(s) are disabling under the rules in § 416.924. These steps are described in more detail in paragraph (b) of this section. Even where medical improvement or an exception applies, in most cases, we will find that your disability has ended only if we also find that you are not currently disabled.

* * * * *

(b) *Sequence of evaluation.* To ensure that disability reviews are carried out in a uniform manner, that decisions of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally, and are fully documented, we follow specific steps in determining whether your disability continues. However, we may skip steps in the sequence if it is clear this would lead to a more prompt finding that your disability continues. For example, we might not consider the issue of medical improvement if it is obvious on the face of the evidence that a current impairment meets the severity of a listed impairment. * * *

(1) *Has there been medical improvement in your condition(s)?* We will determine whether there has been medical improvement in the impairment(s) you had at the time of our most recent favorable determination or decision. (The term medical improvement is defined in paragraph (c) of this section.) If there has been no medical improvement, we will find that your disability continues, unless one of the exceptions to medical improvement described in paragraph (e) or (f) of this section applies.

(i) If one of the first group of exceptions to medical improvement applies, we will proceed to step 3.

(ii) If one of the second group of exceptions to medical improvement applies, we may find that your disability has ended.

(2) *Does your impairment(s) still meet or equal the severity of the listed impairment that it met or equaled before?* If there has been medical improvement, we will consider whether the impairment(s) that we considered at the time of our most recent favorable determination or decision still meets or equals the severity of the listed impairment it met or equalled at that time. In making this decision, we will consider the current severity of the impairment(s) present and documented at the time of our most recent favorable determination or decision, and the same listing section used to make that

determination or decision as it was written at that time, even if it has since been revised or removed from the Listing of Impairments. If that impairment(s) does not still meet or equal the severity of that listed impairment, we will proceed to the next step. If that impairment(s) still meets or equals the severity of that listed impairment as it was written at that time, we will find that you are still disabled, unless one of the exceptions to medical improvement described in paragraphs (e) or (f) of this section applies.

(i) If one of the first group of exceptions to medical improvement applies, we will proceed to step 3.

(ii) If one of the second group of exceptions to medical improvement applies, we may find that your disability has ended.

(3) *Are you currently disabled?* If there has been medical improvement in the impairment(s) that we considered at the time of our most recent favorable determination or decision, and if that impairment(s) no longer meets or equals the severity of the listed impairment that it met or equaled at that time, we will consider whether you are disabled under the rules in §§ 416.924(c) and (d). In determining whether you are currently disabled, we will consider all impairments you now have, including you did not have at the time of our most recent favorable determination or decision, or that we did not consider at that time. The steps in determining current disability are summarized as follows:

(i) *Do you have a severe impairment or combination of impairment?* If there has been medical improvement in your impairment(s), or if one of the first group of exceptions applies, we will determine whether your current impairment(s) is severe, as defined in § 416.924(c). If your impairment(s) is not severe, we will find that your disability has ended. If your impairment(s) is severe, we will then consider whether it meets or medically equals the severity of a listed impairment.

(ii) *Does your impairment(s) meet or medically equal the severity of any impairment listed in appendix 1 of subpart P of part 404 of this chapter?* If your current impairment(s) meets or medically equals the severity of any listed impairment, as described in §§ 416.925 and 416.926, we will find that your disability continues. If not, we will consider whether it functionally equals the severity of a listed impairment.

(iii) *Does your impairment(s) functionally equal the severity of any listed impairment?* If your current impairment(s) functionally equals the severity of any listed impairment, as described in § 416.926a, we will find that your disability continues. If not, we will find that your disability has ended.

(c) * * * Although the decrease in severity may be of any quantity or degree, we will disregard minor changes in your signs, symptoms, and laboratory findings that obviously do not represent medical improvement and could not result in a finding that your disability has ended.

* * * * *

(d) * * * If so, your benefits will continue unless one of the second group of exceptions applies (see paragraph (f) of this section). If not, we will determine whether an attempt should be made to reconstruct those portions of the missing file that were relevant to our most recent favorable determination or decision (e.g., school records, medical evidence from treating sources, and the results of consultative examination).

* * *

(e) *First group of exceptions to medical improvement.* The law provides certain limited situations when your disability can be found to have ended even though medical improvement has not occurred, if your impairment(s) no longer results in marked and severe functional limitations. These exceptions to medical improvement are intended to provide a way of finding that a person is no longer disabled in those situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the person should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, we must also show that your impairment(s) does not now result in marked and severe functional limitations, before we can find you are no longer disabled, taking all your current impairments into account, not just those that existed at the time of our most recent favorable determination or decision. The evidence we gather will serve as the basis for the finding that an exception applies.

(1) *Substantial evidence shows that, based on new or improved diagnostic techniques or evaluations, your impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.* Changing methodologies and advances in medical and other diagnostic techniques or evaluations have given rise to, and will continue to give rise to, improved methods for determining the causes of (i.e., diagnosing) and measuring and documenting the effects of various impairment on children and their functioning. Where, by such new or improved methods, substantial evidence shows that your impairment(s) is not as severe as was determined at the time of our most recent favorable decision, such evidence may serve as a basis for a finding that you are no longer disabled, provided that you do not currently have an impairment(s) that meets or equals the severity of any listed impairment, and therefore results in marked and severe functional limitations.

* * * * *

(f) * * * In these situations, the determination or decision will be made without a finding that you have demonstrated medical improvement or that you are currently not disabled under the rules in § 416.924. * * *

(4) *You fail to follow prescribed treatment which would be expected to improve your impairment(s) so that it no longer results in marked and severe functional limitations.* If treatment has been prescribed for you which would be expected to improve your impairment(s) so that it no longer results in marked and severe functional limitations, you must follow that treatment in order to be paid benefits.

(g) * * *

(5) The first month in which you were told by your physician that you could return to normal activities, provided there is no substantial conflict between your physician's and your statements regarding your awareness of your capacity, and the earlier date is supported by substantial evidence; or

* * * * *

(i) *Requirement for treatment that is medically necessary and available.* If you have a representative payee, the representative payee must, at the time of the continuing disability review, present evidence demonstrating that you are and have been receiving treatment, to the extent considered medically necessary and available, for the condition(s) that was the basis for providing you with SSI benefits, unless we determine that requiring your representative payee to provide such evidence would be inappropriate or unnecessary considering the nature of your impairment(s). If your representative payee refuses without good cause to comply with this requirement, and if we decide that it is in your best interests, we may pay your benefits to another representative payee or to you directly.

(1) *What we mean by treatment that is medically necessary.* Treatment that is medically necessary means treatment that is expected to improve or restore

your functioning and that was prescribed by a treating source, as defined in § 416.902. If you do not have a treating source, we will decide whether there is treatment that is medically necessary that could have been prescribed by a treating source. The treatment may include (but is not limited to)—

(i) Medical management;

(ii) Psychiatric, psychological, or psychosocial counseling;

(iii) Physical therapy; and

(iv) Home therapy, such as administering oxygen or giving injections.

(2) *How we will consider whether medically necessary treatment is available.* When we decide whether medically necessary treatment is available, we will consider such things as (but not limited)—

(i) The location of an institution or facility or place where treatment, services, or resources could be provided to you in relationship to where you reside;

(ii) The availability and cost of transportation for you and your payee to the place of treatment;

(iii) Your general health, including your ability to travel for the treatment;

(iv) The capacity of an institution or facility to accept you for appropriate treatment;

(v) The cost of any necessary medications or treatments that are not paid for by Medicaid or another insurer or source; and

(vi) The availability of local community resources (e.g., clinics, charitable organizations, public assistance agencies) that would provide free treatment or funds to cover treatment.

(3) *When we will not require evidence of treatment that is medically necessary and available.* We will not require your representative payee to present evidence that you are and have been receiving treatment if we find that the condition(s) that was the basis for providing you benefits is not amenable to treatment.

(4) *Removal of a payee who does not provide evidence that a child is and has been receiving treatment that is medically necessary and available.* If your representative payee refuses without good cause to provide evidence that you are and have been receiving treatment that is medically necessary and available, we may, if it is in your best interests, suspend payment of benefits to the representative payee, and pay benefits to another payee or to you. When we decide whether your representative payee had good cause, we will consider factors such as the acceptable reasons for failure to follow prescribed treatment in § 416.930(c) and other factors similar to those describing good cause for missing deadlines in § 416.1411.

(5) *If you do not have a representative payee.* If you do not have a representative payee and we make your payments directly to you, the provisions of this paragraph do not apply to you. However, we may still decide that you are failing to follow prescribed treatment under the provisions of § 416.930, if the requirements of that section are met.

29. Section 416.998 is revised to read as follows:

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

If a new severe impairment(s) begins in or before the month in which your last impairment(s) ends, we will find that your disability is continuing. The new impairment(s) need not be expected to last 12 months or to result in death, but it must be severe enough to keep you from doing substantial gainful activity, or severe enough so that you are still disabled under § 416.994, or, if you are a child, to result in marked and severe functional limitations.

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