regulatory evaluation prepared for this action has been placed in the Rules Docket. A copy of it may be obtained by contacting the Rules Docket at the location provided under the caption **ADDRESSES.**

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the Federal Aviation Administration proposes to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

2. FAA amends § 39.13 by adding a new airworthiness directive (AD) to read as follows:

SOCATA—Groupe Aerospatiale: Docket No. 2001–CE–10AD

(a) *What airplanes are affected by this AD?* This AD affects Model TBM 700 airplanes, serial numbers 1 through 164, that are certificated in any category.

(b) *Who must comply with this AD?* Anyone who wishes to operate any of the above airplanes must comply with this AD.

(c) *What problem does this AD address?* The actions specified by this AD are intended to prevent water from accumulating in the fuselage, then freezing and interfering with or causing the elevator controls to seize. This could result in loss of elevator control with consequent loss of airplane control.

(d) *What actions must I accomplish to address this problem?* To address this problem, you must accomplish the following:

Actions	Compliance	Procedures
Incorporate Kit No. OPT70 K072–53	Within the next 3 months after the effective date of this AD, unless already accomplished.	In accordance with the Technical Instructions supplied with Kit No. OPT70 KO72–53, as specified in Socata. Service Bulletin SB 70–082 53, dated June 2000.

(e) *Can I comply with this AD in any other way?* You may use an alternative method of compliance or adjust the compliance time if:

(1) Your alternative method of compliance provides an equivalent level of safety; and

(2) The Manager, Small Airplane Directorate, approves your alternative. Submit your request through an FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, Small Airplane Directorate.

Note 1: This AD applies to each airplane identified in paragraph (a) of this AD, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For airplanes that have been modified, altered, or repaired so that the performance of the requirements of this AD is affected, the owner/operator must request approval for an alternative method of compliance in accordance with paragraph (e) of this AD. The request should include an assessment of the effect of the modification, alteration, or repair on the unsafe condition addressed by this AD; and, if you have not eliminated the unsafe condition, specific actions you propose to address it.

(f) *Where can I get information about any already-approved alternative methods of compliance?* Contact Karl Schletzbaum, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4146; facsimile: (816) 329–4090.

(g) *What if I need to fly the airplane to another location to comply with this AD?* The FAA can issue a special flight permit under sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate your airplane to a location where you can accomplish the requirements of this AD.

(h) *How do I get copies of the documents referenced in this AD?* You may get copies of the documents referenced in this AD from SOCATA-Groupe AEROSPATIALE, Customer Support, Aerodrome Tarbes-Ossun-Lourdes, BP 930—F65009 Tarbes Cedex, France; telephone: (33) (0)5.62.41.73.00; facsimile: (33) (0)5.62.41.76.54; or the Product Support Manager, SOCATA—Groupe AEROSPATIALE, North Perry Airport, 7501 Pembroke Road, Pembroke Pines, Florida 33023; telephone: (954) 894–1160; facsimile: (954) 964–4191. You may view these documents at FAA, Central Region, Office of the Regional Counsel, 901 Locust, Room 506, Kansas City, Missouri 64106.

Note 2: The subject of this AD is addressed in French AD 2000–373(A), dated October 18, 2000.

Issued in Kansas City, Missouri, on November 5, 2001.

Michael Gallagher,

Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 01–28420 Filed 11–13–01; 8:45 am]

BILLING CODE 4910–13–P

SOCIAL SECURITY ADMINISTRATION

20 CFR Part 404

[Regulations No. 4]

RIN 0960–AF28

Revised Medical Criteria for Evaluating Impairments of the Digestive System

AGENCY: Social Security Administration.

ACTION: Proposed rules.

SUMMARY: We are proposing to revise the criteria in the Listing of Impairments (the Listings) that we use to evaluate claims involving digestive impairments. We apply these criteria at step three of our sequential evaluation processes when you claim benefits based on disability under title II and title XVI of the Social Security Act (the Act). The proposed revisions will reflect advances in medical knowledge, treatment, and methods of evaluating digestive impairments. We also propose to remove listings that are redundant and only refer to other listings.

DATES: To be sure your comments are considered, we must receive them by January 14, 2002.

ADDRESSES: You may give us your comments by using: our Internet site facility (*i.e.,* Social Security Online) at *http://www.ssa.gov/regulations/index.htm,* e-mail to *regulations@ssa.gov,* telefax to (410) 966–2830 or by sending a letter to the Commissioner of Social Security, P.O. Box 17703, Baltimore, Maryland 21235–7703. You may also deliver them to the Office of Process and Innovation Management, Social Security Administration, L2109 West Low Rise Building, 6401 Security Boulevard, Baltimore, Maryland 21235–6401, between 8 a.m. and 4 p.m. on regular business days. We post comments on our Internet site, or you may inspect them on regular business days by making arrangements with the contact person shown in this preamble.

A list of the sources we consulted when developing these proposed rules, *e.g.,* various medical texts and pertinent articles, will be posted on the above Internet site. The list is also available upon request by letter to the Office of Disability, Division of Medical & Vocational Policy, Social Security Administration, 3√A–8 Operations Building, 6401 Security Boulevard, Baltimore, MD 21235, Attn: Cheryl Wrobel, or by email to Cheryl.Wrobel@SSA.gov. Electronic Version: The electronic file of this document is available on the date of

publication in the **Federal Register** on *http://www.access.gpo.gov/su_docs/aces/aces140.html.* It is also available on the Internet site for SSA (*i.e.,* Social Security Online): *http://www.ssa.gov/regulations/.* Electronic copies of the public comments on these proposed rules may also be found on this site.

FOR FURTHER INFORMATION CONTACT: Suzanne DiMarino, Social Insurance Specialist, Office of Process and Innovation Management, Social Security Administration, 2109 West Low Rise, 6401 Security Boulevard, Baltimore, Maryland 21235–6401, (410) 965–1769 or TTY (410) 966–5609. For information on eligibility or filing for benefits, call our national toll-free number 1–800–772–1213 or TTY 1–800–325–0778, or visit our Internet web site, SSA Online, at *www.ssa.gov.*

SUPPLEMENTARY INFORMATION:

What Programs Would These Proposed Regulations Affect?

These proposed regulations would affect disability determinations and decisions we make for you under title II and title XVI of the Act. In addition, to the extent that Medicare and Medicaid eligibility are based on entitlement to benefits under title II and eligibility for benefits under title XVI, these proposed regulations would also affect the Medicare and Medicaid programs.

Who Can Get Disability Benefits?

Under title II of the Act, we provide for the payment of disability benefits if you are disabled and belong to one of the following three groups:

- Workers insured under the Act;
- Children of insured workers; and
- Widows, widowers, and surviving divorced spouses of insured individuals.

Under title XVI of the Act, we provide for Supplemental Security Income (SSI) payments on the basis of disability if you have limited income and resources.

How Do We Define Disability?

Under both the title II and title XVI programs, disability must be the result of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of at least 12 months. Our definitions of disability are shown in the following table:

If you file a claim under * * *	And you are * * *	Disability means you have a medically determinable impairment(s) that meets the statutory duration requirement and results in * * *
title II	an adult or child	the inability to do any substantial gainful activity (SGA).
title XVI	an adult	the inability to do any SGA.
title XVI	a child	marked and severe functional limitations.

What Are the Listings and How Do We Use Them?

The Listings, found in appendix 1 to subpart P of part 404 of our regulations, are examples of impairments for each of the major body systems that we consider severe enough to preclude you as an adult from performing any gainful activity, without further considering their functional impact or your age, education and work experience. If you are a child seeking SSI benefits based on disability, the listings describe impairments that we consider severe enough to result in marked and severe functional limitations. We generally use the criteria in the Listings only to make findings of disability. Although the Listings are found only in part 404 of our rules, we incorporate them into the SSI program under title XVI of the Act by § 416.925 of our regulations, and apply them to claims under both title II and title XVI of the Act.

There are listings for adults (part A) and for children (part B). We apply the medical criteria in part A when we assess your claim if you are an adult, *i.e.,* a person age 18 or over. If you are a child, we first use the criteria in part B. If the B criteria do not apply, and the specific disease process(es) has a similar effect on adults and children, we then use the criteria in part A.

Our regulations provide for sequential evaluation processes for evaluating disability. We apply the Listings at step three of the sequential evaluation processes for adults and for children. First, we must determine that you are not engaging in substantial gainful activity, and, second, that you have a medically determinable impairment or combination of impairments that is ''severe.''

Then, at step 3 of both processes, we use the Listings to determine if you have an impairment(s) that meets or equals in severity the criteria of a listed impairment.

Why Are We proposing To revise the Listings for Digestive Impairments?

We have reviewed the existing digestive listings and have determined they should be revised in light of medical advances in evaluation and treatment. We last published final rules revising the digestive listings in the **Federal Register** on December 6, 1985 (50 FR 50068). In the preamble to those rules, we said that due to medical advances in treatment and program experience, we would periodically review and update the Listings. The current listings for the digestive system will no longer be effective on July 2, 2003. We are now proposing to revise the listings in Part A, 5.00 and in Part B, 105.00. We are proposing to make the rules effective for five years from the effective date of the final rules we publish in the **Federal Register**, unless we extend them, or revise and issue them again.

We will continue to apply our current listings until we evaluate the public comments on these proposed rules and determine whether they should be issued as final rules. If we finalize these proposed rules, when any final rules become effective, we will apply them to new applications filed on or after the effective date of the final rules, and to cases that are pending in the administrative review process. In accordance with our usual practice, we would explain how we would apply any final rules in greater detail in the preamble to the final rules.

When we conduct reviews to determine whether your disability continues, we would not find that your disability has ended based only on any changes in the listings. Our regulations explain that we continue to use our prior listings when we review your case if you receive disability benefits or SSI payments based on our determination or decision that your impairment(s) met or equaled the listings. In these cases, we determine whether you have experienced medical improvement, and if so, whether the medical improvement is related to the ability to work. If your impairment(s) still meets or equals the same listing section that we used to make our most recent favorable determination or decision, we will find the medical improvement is not related to the ability to work. If your condition has medically improved so that you no longer meet or equal the prior listing, we evaluate your case further to determine whether you are currently disabled. We may find that you are

currently disabled, depending on the full circumstances of your case. See 20 CFR 404.1594(c)(3)(i), 416.994(b)(2)(iv)(A). If you are a child who is eligible for SSI payments, we follow a similar rule when we decide whether you have experienced medical improvement in your condition. 20 CFR 416.994a(b)(2).

What General Revisions Are We Proposing for the Digestive System Listings?

We propose to clarify the listing criteria and to make the listings easier to use by:

1. Replacing reference listings with guidance in the preface. Reference listings are listings that are met by satisfying the criteria of another listing. For example, you can meet current listing 5.03, Stricture, stenosis, or obstruction of the esophagus, with weight loss as described under listing 5.08. Current listing 5.08 requires weight loss to a specific amount due to any persisting gastrointestinal disorder. Therefore current listing 5.03 is redundant.

We also propose to provide general guidance in the preface to the listings (see Section 5.00E1) stating that digestive disorders resulting in impairments in other body systems should be evaluated under the affected body system. We propose to list the most commonly affected body systems.

2. Making nonsubstantive editorial changes to update the medical terminology in the Listings and to be consistent with plain language guidelines. Plain language regulations will make the content easier to understand.

We discuss other specific changes we propose to make in the listings below, in our detailed explanation of the proposed listings.

How Are We Proposing to Change the Preface to the Listings for Evaluating Digestive Impairments in Adults?

5.00 Digestive System

We propose to revise the preface to provide additional guidance for adjudicating digestive impairments, and to update the medical terminology. We also propose to remove references to disorders and complications of diseases that we no longer always consider to result in listing-level severity, *e.g.,* peptic ulcer disease, fistulae, abscesses, or recurrent obstructions.

The remaining relevant material in current section 5.00A is in proposed section 5.00A, while the relevant material in current 5.00B is updated and moved to proposed section 5.00F.

The relevant material in current section 5.00C is moved to proposed section 5.00A. We propose to remove that portion of current section 5.00C that deals with peptic ulcer disease because advances in diagnosis, evaluation and treatment of this impairment make the surgical interventions discussed in the current section (including gastrectomy, vagotomy and pyloroplasty) much less common.

Following is a detailed explanation, section-by-section, of the proposed revised preface material.

Proposed 5.00A—What Kind of Impairments Do We Consider in the Digestive System?

In this section, we propose to list examples of major digestive impairments reflected in the digestive listings. We propose to move the information about colostomy and ileostomy from current section 5.00C to proposed section 5.00A. as part of a general reorganization of the material.

The proposed rules continue to recognize that digestive impairments frequently respond to medical or surgical therapy. As a result, the severity of these disorders should generally be considered within the context of prescribed treatment.

Proposed 5.00B—What Documentation Do We Need?

In this new section, we propose to add examples of the types of clinical and laboratory findings that should be part of the longitudinal evidence. We also state that we usually need longitudinal evidence covering a period of at least 6 months of observations and treatment, unless we can make a fully favorable determination or decision without it. With advances in medication and treatment, favorable response to treatment may reduce the functional impact of digestive impairments. We believe the 6-month evidence period should allow sufficient time for your impairment to stabilize so we can make an accurate projection regarding its severity and duration. However, this does not prevent us from making a finding of disability before the 6-month period elapses, after considering all of the medical and other evidence. The rules we have proposed will provide us with flexibility to address situations in which your medical condition is so severe that we can determine before the 6-month period elapses that your impairment(s) will continue to be disabling for at least 12 months. One example would be under listing 5.02, recurrent gastrointestinal hemorrhage, if 3 distinct episodes are documented in less than 6 months. Another example would be an impairment that meets listing 5.09 Liver transplant, due to a traumatic event or previously unrecognized and untreated liver condition with little or no pre-surgical treatment documentation.

We also provide guidance on those situations when you have not received ongoing treatment or do not have an ongoing relationship with the medical community despite the existence of a severe impairment.

Proposed 5.00C—How Do We Evaluate Digestive Disorders Under Listings That Require Recurring or Persistent Findings?

We propose this new section to discuss the requirement for recurring or persistent findings in listings 5.02, 5.05, 5.06 and 5.08, and other considerations which allow us to make findings regarding continued impairment severity to satisfy the duration of disability requirement.

We also discuss the events and episodes needed to meet certain listings. There are no minimal periods of time for which an episode has to last, although for some listings, all incidents within a specified period will constitute one episode. The duration of an episode is controlled by the requirements that constitute an episode for a specific disorder. For example, the requirement for blood transfusion inherently implies that you must seek medical care that results in the appropriate clinical and laboratory evaluation to determine that transfusion is necessary.

The required number of recurrent episodes is specified in each listing. Listings 5.02, 5.06, 105.05A, and 105.06A are characterized by ''episodes.''

Listing 5.02 requires 3 episodes of gastrointestinal hemorrhage requiring at least two units of blood transfused per episode, occurring during a consecutive 6-month period. Listing 5.02 further qualifies that all incidents occurring within a consecutive 14-day period constitute one episode. Listing 5.06 and 105.06A require documentation of at least two episodes of abdominal pain, distention, and vomiting as a result of inflammatory bowel disease, which is documented as required in the listing. These episodes must occur during the consecutive 6-month period of persistent or recurrent intestinal obstruction that occurs despite prescribed treatment. Listing 105.05A requires 3 episodes of bleeding requiring transfusion due to hemodynamic instability, occurring over a consecutive 6-month period.

Section 5.00C2 and 105.00C2 explain: * * * In every listing in which we require more than one event, there must be at least 1 month between the events (unless otherwise specified), to ensure that we are evaluating separate episodes.''

Proposed 5.00D—How Do We Consider the Effects of Treatment?

We propose this new section to describe our policy on assessing the effects of treatment when we determine the severity and duration of the impairment.

Proposed 5.00E—How Do We Evaluate Impairments That Do Not Meet One of the Digestive Listings?

In this new section, we propose guidance for assessing digestive impairments that do not meet the digestive listings, but are accompanied by systemic manifestations in other body systems. For example, we site hepatic encephalopathy to explain that the resultant impairment should be evaluated under the affected body system. This replaces the criteria in current listing 5.05E, which states the impairment should be evaluated under the criteria in listing 12.02.

We also explain how evaluation of the impairment(s) will continue through the sequential evaluation process.

Proposed 5.00F—What Are Our Guidelines for Evaluating Specific Digestive Impairments?

We incorporated and revised the guidance in current 5.00B into this proposed section. We removed the discussion in current section 5.00B about a distinction between primary and secondary digestive disorders resulting in weight loss and malnutrition since the distinction is not necessary for adjudication. Rather, the weight loss must only be shown to be related to a digestive impairment. When a medically determinable impairment is established, we do not require that a direct connection with a specific etiology be determined. The wording in current 5.00B can be incorrectly interpreted to imply that we must determine that the digestive disorder is the primary or secondary cause of the weight loss. Since this is not necessary for our disability evaluation process, we propose to revise the section. If you have a digestive disorder that can reasonably be expected to lead to weight loss, or a treating source actually states that weight loss results from a specific digestive disorder, this is sufficient for our purposes.

We added an explanation of how to use the weight tables in Listing 5.08, when fractions of inches or centimeters in height measurements must be converted to specific table values.

We also propose to add a new section, 5.00F2, which describes how we evaluate chronic liver disease and resulting impairments, including liver transplants.

How Are We Proposing to Change the Criteria in the Listings for Evaluating Digestive Impairments in Adults?

5.01 Category of Impairments, Digestive System

Addition of new listing:

We propose to add a new listing, 5.09 Liver Transplant, in keeping with our other organ transplantation listings, *e.g.* heart transplant in listing 4.09 and kidney transplant in listing 6.02B.

Removal of redundant or reference listings:

We propose to remove several current listings because they are redundant. These four listings are all reference listings referring to listing 5.08:

- 5.03—Stricture, stenosis, or obstruction of the esophagus with weight loss,
- 5.04D—Peptic ulcer disease with weight loss,
- 5.06E—Chronic ulcerative or granulomatous colitis with weight loss, and
- 5.07D—Regional enteritis with weight loss.

We propose to remove listing 5.05E because it is a reference listing to 12.02. We propose to add language to the preface in 5.00E to refer to the appropriate body system that may be affected by a digestive impairment.

We propose to remove several listings or listing sections because there has been significant progress in medical technology and clinical experience related to the treatment of the digestive impairments that are contained in the current listings. Our program experience is that such advances in treatment mean that the criteria in some of the current listings are no longer appropriate indicators of listing-level severity. Many of these impairments can be controlled or resolved and thus are less likely to result in listing-level severity. Even if listing-level severity is initially present, the 12 month statutory duration requirement may no longer be met.

We propose to remove current listing 5.04, Peptic ulcer disease (demonstrated by X-ray or endoscopy), due to progress in evaluation and treatment.

Advances in medical and surgical management have made many complications from peptic ulcer disease such as recurrent ulceration (current listing 5.04A), fistula formation (current listing 5.04B) and recurrent obstruction (current listing 5.04C) less common. Treatment often results in significant improvement so that the criteria in these listings are no longer an appropriate indicator of listing-level severity. Therefore, we propose to remove all three current peptic ulcer disease listings.

We also propose to remove several of the chronic liver disease listings, listing 5.05, due to progress in treatment and other reasons as described:

- 5.05B—Chronic liver disease with performance of a shunt operation for esophageal varices. At the time this listing was written, only surgical shunts were available. Surgical shunts involve extensive abdominal surgery. They were not usually performed until your condition became serious enough to warrant undertaking the risks associated with prolonged surgery and anesthesia. Surgical shunts are now performed much less frequently. Clinical experience indicates that procedures such as the transjugular intrahepatic portal systemic shunt (TIPS), may be performed with minimal anesthesia and with fewer complications.

TIPS represents an advance in the medical management of portal hypertension and massive ascites. Indications for a TIPS procedure include bleeding esophageal varices or refractory ascites.

- 5.05C—Chronic liver disease with specific levels of serum bilirubin. Current listing 5.05C requires only a persistent elevated bilirubin level. We propose to delete this listing because a laboratory finding alone is not an accurate measure of your ability to function.
- 5.05F—Chronic liver disease with liver biopsy. This listing requires confirmation of chronic liver disease by a liver biopsy, with a specified clinical or laboratory finding. We propose to delete this listing because it does not necessarily characterize an impairment of listing-level severity. A liver biopsy, while confirming the presence of liver disease, does not correlate with any specific level of impairment severity or decrease in functional ability. The biopsy only confirms what may have been discovered with imaging and other laboratory evidence. The specific laboratory values in the listing also are not an accurate measure of the severity and duration of the impairment. Proposed listing 5.05 will replace many of the criteria in current 5.05 to reflect more accurately listing-level impairments related to chronic liver disease.

We also propose to remove current listing 5.06, Chronic ulcerative or

granulomatous colitis and current listing 5.07, Regional enteritis for the following reasons:

• 5.06A—Chronic ulcerative or granulomatous colitis with recurrent bloody stools documented on repeated examinations and anemia manifested by hematocrit of 30 percent or less.

Anemia, when caused by inflammatory bowel disease, is not an appropriate indicator of listing-level severity. Hematocrit level does not necessarily correlate with ability to function. A gradual reduction in hemoglobin, even to very low levels, is often well tolerated if you have normal cardiovascular and pulmonary systems.

• 5.06B and 5.07B—Persistent or recurrent systemic manifestations, such as arthritis, iritis, fever or liver dysfunction due to chronic ulcerative or granulomatous colitis or regional enteritis. These listings required only the presence of a systemic manifestation in another body system or organ, without regard to degree of severity of functional impact. These listings are not an appropriate indicator of listing-level severity.

• 5.06C and 5.07C—Intermittent obstruction due to intractable abscess, fistula formation or stenosis. Advances in surgical treatment have improved the management of these conditions, so that these listings are no longer an appropriate indicator of listing-level severity.

• 5.06D—Recurrence of findings of A, B, or C after total colectomy. We are proposing to remove this listing consistent with our proposal to remove listings 5.06A, B, and C.

We propose to combine the remainder of listings 5.06—Chronic ulcerative or granulomatous colitis, and 5.07—Regional enteritis, into one listing for inflammatory bowel disease (IBD) (proposed listing 5.06). IBD includes both ulcerative colitis and Crohn's disease. Crohn's disease includes regional enteritis. Crohn's disease may involve the entire gastrointestinal tract, but usually involves the small intestine or colon.

We also propose to remove current listing 5.08B, Weight loss due to any persisting gastrointestinal disorder, with weight equal to or less than the values specified in Table III or IV and one of the listed abnormal laboratory findings present on repeated examinations. This listing allowed a lesser level of weight loss than that required to meet listing 5.08A when accompanied by one of the additional listed findings. Those findings, however, do not correlate with any specific level of impairment severity or decrease of functional ability that would be an accurate indicator of listing-level severity.

The following is a detailed explanation of the proposed listing criteria.

Proposed Listing 5.02—Recurrent Gastrointestinal Hemorrhage

We propose to revise the severity criteria in this listing from anemia with a hematocrit level of 30 percent or less, to the requirement for at least 2 units of blood transfused per episode, with hemorrhages occurring at least three times during a consecutive six-month interval. A hematocrit level is not an appropriate indicator of the severity of gastrointestinal hemorrhage. It is the frequent recurrence of the hemorrhages and the cumulative effect on you that results in your inability to perform any gainful activity. We also propose to revise the source of gastrointestinal bleeding covered by this listing from ''upper gastrointestinal hemorrhage from undetermined cause'' to ''gastrointestinal hemorrhage from any cause.''

Since improvements in medical treatment may resolve the frequency of hemorrhages and thus the overall severity of the impairment, we propose that you may be considered to be under a disability for one year following the last documented hemorrhage. Thereafter, we will evaluate your residual impairment(s).

Proposed Listing 5.05—Chronic Liver Disease

We propose to replace current listing 5.05 with criteria that more accurately reflect listing-level severity.

We propose to remove ''portal, postnecrotic, or biliary cirrhosis'' in the current listing 5.05 and replace it with ''cirrhosis of any kind.'' We listed these kinds of cirrhosis as examples of chronic liver disease, but we did not intend that we must specify the kind of cirrhosis present. Removing the examples would clarify our intent. We also propose to remove ''Wilson's disease'' and ''chronic active hepatitis'' from the examples of chronic liver disease because hepatic impairment due to Wilson's disease and chronic active hepatitis is included in the revised term ''cirrhosis of any kind.''

We propose to revise listing 5.05A, esophageal varices, by defining our criteria for a massive hemorrhage. By providing a specific transfusion requirement, we intend to exclude minor variceal bleeding which would not be an indicator of listing-level severity.

Newer techniques in primary prevention and treatment of esophageal varices, *e.g.,* TIPS, banding, and sclerotherapy, have significantly improved the management of varices. Based on these advances, it is no longer appropriate to establish disability for 3 years as under current listing 5.05A, so we propose that you will be considered under a disability for one year following the last documented massive hemorrhage. Thereafter, we will evaluate your residual impairment(s).

We are proposing to change current listing 5.05D, ascites due to chronic liver disease, to 5.05B. We propose to clarify how the persistence of the ascites over 6 months must be demonstrated. We are revising the required time interval from 5 months of ascites to 6 months of ascites to be consistent with the other proposed digestive system listings. In our experience, requiring 6 months of persistent findings enables us to make a more reliable prediction of listing-level severity. We also require that evaluations be done at least two months apart within the six-month period to substantiate the chronic nature of the impairment, and to ensure that we are evaluating separate episodes.

The presence of sufficient ascitic fluid *requiring* frequent paracentesis indicates disease of listing-level severity. Under current listing 5.05D, if paracentesis was not performed, ascites sufficient to be detected on physical examination, along with hypoalbuminimia would fulfill these criteria. However, current imaging techniques are capable of identifying even minimal amounts of ascites before they could be detected on physical examination, which would not be an indicator of listing-level severity liver disease. We explain this in the preface.

If ascites is documented by medically acceptable imaging rather than by paracentesis, we still require evidence to confirm that there is significant deterioration of liver function. Therefore, we propose in listing section 5.05B2 to require reduction of serum albumin to the level specified in the listing or prolongation of the prothrombin time as specified in the listing.

Proposed Listing 5.06—Inflammatory Bowel Disease

We propose to combine portions of current listings 5.06 and 5.07 into listing section 5.06. Ulcerative colitis, Crohn's disease, granulomatous colitis, and regional enteritis are now commonly referred to as ''Inflammatory bowel disease'' (IBD). Combining these listings is appropriate considering current medical practice. The listing-level criteria for IBD concern persistent or recurrent intestinal obstruction. These criteria reiterate current listing 5.07A.

and also clarify that the intestinal obstruction must be documented by appropriate medically acceptable imaging, or operative findings. We propose the additional requirement that two episodes of obstruction over a consecutive 6-month period despite prescribed therapy be documented in order to ensure that this is a chronic impairment that will meet the 12-month duration requirement, rather than a single occurrence that can be successfully treated.

Proposed Listing 5.08—Weight Loss Due to Any Persisting Gastrointestinal Disorder

We propose that the weight level demonstrating listing-level severity be documented for at least 6 consecutive months, despite prescribed therapy and expected to persist at this level for at least 12 months, in order to ensure the continuing nature of the impairment. Weight loss of shorter duration may respond to treatment, and therefore may not be expected to persist for 12 months. Since these listings were originally written, there have been significant advances in the treatment of many digestive disorders, which have resulted in more favorable prognoses with treatment. However, it may take up to 6 months to determine whether treatment will lead to long-term improvement and possibly recovery, or just result in a temporary remission of impairment severity. In light of the current medical knowledge, we believe that 6 months is the minimum amount of time needed to determine that the weight loss due to a digestive impairment will continue at listing-level severity for long enough to fulfill the duration requirement of 12 months. This is consistent with the changes we propose in the other digestive listings.

We also propose to update the weights listed in Tables I and II of listing 5.08. While we are proposing to adopt the use of Body Mass Index (BMI) in evaluating malnutrition in children (listing 105.08), we are not, at this time, proposing to adopt BMI to evaluate weight loss in adults. The Centers for Disease Control and Prevention (CDC) state that BMI is used differently with children than it is with adults. ''* * * Body Mass Index, or BMI (wt/ht^2) provides a guideline based on weight and height to determine underweight and overweight. As children grow, their body fatness changes over the years. The interpretation of BMI depends on the child's age. Additionally, girls and boys differ in their body fatness as they mature. Therefore, we plot the BMI-for-age according to sex-specific charts.'' The CDC has prepared charts and tables that calculate BMI values for selected heights and weights for you from ages 2 to 20 years. The CDC has further determined that a BMI-for-age <5th percentile meets their criteria for underweight. The CDC does not calculate a figure nor indicate a cutoff that is judged to be indicative of malnutrition.

The current listings are based on standard growth charts to satisfy the listing for malnutrition. Current listing 105.08 requires (in part): ''Malnutrition, due to a demonstrable gastrointestinal disease causing either a fall of 15 percentiles of weight which persists or the persistence of weight which is less than the third percentile (on standard growth charts).

The 3rd percentile is generally accepted as the lower limit of the normal range for most biologic measurements. Persistence below this level would warrant evaluation and, if available, intervention. Since the new BMI-for-age charts continue to provide percentiles, we are able to continue our policy of measurements below the 3rd percentile determined to correspond with listing-level severity for children.

In assessing weight loss in adults, we have never used percentiles based on age calculations. Our current listing 5.08 is based on the Metropolitan Life Insurance Company's weight chart for medium frame individuals. The weights in tables 1 and 2 of listing 5.08 represent a 20% reduction in the beginning weight for medium frame individuals as reflected in the weight charts in effect at the time the listings were last revised.

The CDC has no such BMI-for-age charts for adults. They do state that ''underweight'' in adults is indicated by a BMI less than 18.5; however, neither the CDC nor any other recognized authority known to us has determined a BMI for adults that would be consistent with listing-level severity weight loss due to a gastrointestinal impairment. Until we have a scientific basis for changing the way we calculate listing-level severity weight loss in adults, we determined it would be best to just update our tables 1 and 2 using the latest Metropolitan Life Insurance Company's weight chart, last updated in 1983.

We also expanded the heights and weights in the tables to add the metric equivalents for assistance in adjudication.

The weight loss tables in listing 5.08 include listing-level weights for men whose height is between 5 feet 1 inch and 6 feet 4 inches, and for women whose height is between 4 feet 10 inches and 6 feet 1 inch. If your height is outside these table values and you allege disability due to weight loss related to a digestive impairment, these tables cannot be applied to evaluate whether your impairment meets the listing. In this situation, we would review the evidence in file to determine if your condition medically equals the listing. Considering the table weights and your weight, we would make a severity judgment. If you have a severe impairment that does not meet nor equal the listings, we continue to evaluate your claim through the sequential evaluation process, which would require assessment of your residual functional capacity and, if necessary, consideration of vocational factors such as your age, education and past work experience.

Proposed Listing 5.09—Liver Transplant

We propose that you should be considered under a disability for 12 months following the surgery, due to the nature and course of recovery for this procedure. After that time, we will evaluate the residual impairment(s). This is consistent with our criteria for assessing other organ transplants, such as kidney and heart.

How Are We Proposing To Change the Preface To the Listings for Evaluating Digestive Impairments in Children?

105.00 Digestive System

As we already discussed in the explanation of 5.00 in the adult rules, we propose to revise the preface to provide additional guidance for adjudicating digestive impairments. Where necessary, we added information specific to the childhood listings; however, we repeated much of the proposed preface 5.00 in the proposed preface 105.00. This is because the same basic rules for establishing and evaluating the existence and severity of digestive impairments in adults also apply to children.

Proposed 105.00A through 105.00F correspond to proposed 5.00A through 5.00F in the adult rules. Because we already described these provisions under the explanation of proposed 5.00, the following discussions describe only those provisions that are unique to the childhood rules or that require further explanation.

Proposed 105.00A—What Kind of Impairments Do We Consider in the Digestive System?

This section contains the information in current 105.00A, and information from the last sentence in current 105.00C. It differs from the corresponding 5.00A in the proposed adult rules in the following ways:

• We added a paragraph addressing congenital defects of the gastrointestinal organs; and

• We added ''growth and development'' to ''nutrition'', in the paragraph addressing surgical diversions of the intestinal tract, since these factors are relevant to the assessment of disability in children.

Proposed 105.00B—What Documentation Do We Need?

This section contains the information in current 105.00B. We made editorial changes to refer to ''children'' rather than ''individuals'' and changes to reflect the sequential evaluation of disability for children. Aside from these changes, the only substantive difference between this section and the corresponding proposed section for adults is the addition of ''assessment(s) of growth and development'' to the list of types of evidence that we consider.

Proposed 105.00C—How Do We Evaluate Digestive Disorders Under Listings That Require Recurring or Persistent Findings?

This is a new section. It differs from the corresponding proposed 5.00C in the adult rules, only in that it references childhood listings 105.05, 105.06, and 105.08, rather than adult listings.

Proposed 105.00D—How Do We Consider the Effects of Treatment?

This is a new section that corresponds to the proposed adult section 5.00D.

Proposed 105.00E—How Do We Evaluate Impairments That Do Not Meet One of the Digestive Listings?

This is a new section. It contains two subsections that do not appear in the proposed adult rules. Subsection 105.00E1b includes the information in current 105.00D about multiple anomalies and subsection 105.00E1c contains an updated version of the information in the first two sentences of current 105.00C about digestive impairments and reduction in the rate of growth.

We also explain how evaluation of your impairment(s) will continue through the sequential evaluation process. We added a sentence about functionally equaling the listings, with a cross-reference to the appropriate regulatory citation.

Proposed 105.00F—What Are Our Guidelines for Evaluating Specific Digestive Impairments?

This section contains the information in the first two sentences of current 105.00C. The rest of the information in this section is new. It is divided into four subsections: Malnutrition, weight loss and growth retardation; Chronic liver disease; Esophageal stricture or stenosis; and Inflammatory bowel disease.

In subsection 105.00F1a, we explain how to evaluate weight loss and growth retardation that result from malnutrition. We also list examples of laboratory findings that represent chronic nutritional deficiency. In the revised listing 105.08, we require a documented sign of chronic nutritional deficiency to confirm the existence of a gastrointestinal disease resulting in malnutrition. We do not include these specific findings in the listing language because the required laboratory finding(s) are not limited to one of these specific examples. We will also accept other medically acceptable laboratory findings that represent chronic nutritional deficiency.

Since we also are proposing to revise listing 105.08 by using Body Mass Index (BMI) measurements, we added a discussion of these measurements in subsection 105.00F1b.

The Centers for Disease Control and Prevention (CDC) state that BMI is used differently with children than it is with adults. ''* * * Body Mass Index, or BMI (wt/ht^2) provides a guideline based on weight and height to determine underweight and overweight. As children grow, their body fatness changes over the years. The interpretation of BMI depends on the child's age. Additionally, girls and boys differ in their body fatness as they mature. Therefore, we plot the BMI-for-age according to sex-specific charts.'' The CDC has prepared charts and tables that calculate BMI values for selected heights and weights for you from ages 2 to 20 years. The CDC has further determined that a BMI-for-age <5th percentile meets their criteria for underweight. The CDC does not calculate a figure nor indicate a cutoff that is judged to be indicative of malnutrition.

The current listings are based on standard growth charts to satisfy the listing for malnutrition. Current listing 105.08 requires (in part): ''Malnutrition, due to a demonstrable gastrointestinal disease causing either a fall of 15 percentiles of weight which persists or the persistence of weight which is less than the third percentile (on standard growth charts).

The 3rd percentile is generally accepted as the lower limit of the normal range for most biologic measurements. Persistence below this level would warrant evaluation and, if available, intervention. Since the new BMI-for-age charts continue to provide percentiles, we are able to continue our policy of measurements below the 3rd percentile determined to correspond with listing-level severity for children.

The new subsection on chronic liver disease, section 105.00F2, corresponds to the information in the proposed adult rules, except that we also added a discussion on portal hypertension in proposed 105.00F2C because chronic liver disease in children often presents as complications of portal hypertension.

Section 105.00F3 addresses esophageal stricture or stenosis. This new preface section gives guidance in adjudicating this impairment when the malnutrition listing is not met.

Section 105.00F4 discusses the documentation of an intractable perineal or intra-abdominal complication, such as intractable fecal incontinence.

How Are We Proposing To Change the Criteria in the Listings for Evaluating Digestive Impairments in Children?

105.00 Category of Impairments, Digestive System

Addition of new listing:

As in the proposed adult rules, we propose to add a new listing for children to address liver transplantation. The new listing will be 105.09, liver transplant.

Removal of redundant or reference listings:

We propose to remove these listings because they refer to listing 105.08:

• 105.03—Esophageal obstruction, caused by atresia, stricture or stenosis, and

• 105.07B—Chronic inflammatory bowel disease with malnutrition.

These listings are met only when listing 105.08—Malnutrition, due to demonstrable gastrointestinal disease, is met. As we noted above, we are proposing to remove reference listings because they are redundant.

We also propose to remove these other reference listings:

• 105.05E—Chronic liver disease with hepatic encephalopathy. This reference listing directs us to evaluate the impairment under the criteria in 112.02—Organic mental disorders. Hepatic encephalopathy is addressed in proposed section 105.00E1a of the preface, which states that the impairment should be assessed under the criteria for the appropriate mental disorder or neurological listing.

• 105.07C—Chronic inflammatory bowel disease, with growth impairment as described under the criteria in 100.03. This listing refers us to the criteria in listing 100.03—Growth impairment. We propose to add material

to the preface in 105.00E1c and 105.00F1a to address assessment of these impairment manifestations.

As in the proposed adult rules, we propose to remove several listings or listing sections since there has been significant progress in medical technology and clinical experience related to the treatment of digestive impairments. Our program experience shows that because of these advances the criteria in some of the current listings can no longer be considered to result in marked and severe functional limitations. Even if listing-level severity is initially present, the statutory duration requirement may no longer be met.

We propose to remove the following chronic liver disease listings:

• 105.05A.—Chronic liver disease with inoperable biliary atresia. Children with this impairment often receive transplants and they would be evaluated under the proposed new listing 105.09—liver transplant. Otherwise, manifestations of this disease would be evaluated under the other liver disease listings.

• 105.05D.—Chronic liver disease with hepatic coma. Hepatic coma, like hepatic encephalopathy, will now be assessed under the criteria for the appropriate mental or neurological listings.

• 105.05F.—Chronic liver disease with chronic active inflammation or necrosis documented by SGOT persistently more than 100 units or serum bilirubin of 2.5 mg. percent or greater. We propose to remove this listing because it requires only a persistent laboratory finding. Based on our program experience, a laboratory finding alone is not an accurate measure of the severity or duration of the impairment.

The following is a detailed explanation of the proposed listing criteria.

Proposed Listing 105.05—Chronic Liver Disease

We propose to add ''cirrhosis of any kind,'' for consistency with the proposed adult rules.

We propose to revise current listing 105.05C.—Chronic liver disease with esophageal varices, and renumber it as proposed listing 105.05A. We have added the requirement for bleeding attributable to the varices because the mere presence of esophageal varices, by itself, does not necessarily result in marked and severe functional limitations. As in the proposed adult listings, we have provided a specific transfusion requirement to exclude minor variceal bleeding which is not an indicator of listing-level severity. The transfusion requirement for children is based on frequency of needed transfusions, rather than amount of blood transfused, because in children, blood transfusions are only administered in cases of extreme need and the amount of blood transfused is variable depending on body size.

We propose to revise current listing 105.05B—Chronic liver disease with intractable ascites, by removing the albumin level requirement. Persistent ascites related to chronic liver disease is an impairment of listing-level severity in children, regardless of serum albumin level.

As explained in the preamble concerning the comparable adult listing, the presence of sufficient ascitic fluid *requiring* frequent paracentesis indicates disease of listing-level severity. However, current imaging techniques are capable of identifying even minimal amounts of ascites before they could be detected on physical examination, which would not be an indicator of listing-level severity liver disease; thus, in the absence of paracentesis, we require ascites to be documented on physical examination and by medically appropriate imaging techniques. We explain this in the preface.

Proposed Listing 105.06—Inflammatory Bowel Disease

We propose to renumber current listing 105.07—Chronic inflammatory bowel disease, to proposed listing 105.06, for consistency with the corresponding proposed adult listing. We are revising and clarifying current 105.07A—Chronic inflammatory bowel disease with intestinal manifestations or complications, which becomes the only listing under proposed 105.06. We added the requirements for persistent or recurrent findings to ensure a frequency or duration of impairment consistent with listing-level severity. We also now require appropriate medically acceptable imaging evidence of the impairment. We are also adding a requirement for functionally limiting signs and symptoms that are characteristic of the impairment. Since inflammatory bowel disease can affect the entire digestive tract, we added an alternate subsection for perineal or intra-abdominal complications.

Proposed Listing 105.08—Malnutrition

We propose to revise this section to be consistent with the new weight-for-length and Body Mass Index (BMI) measurements, growth charts and data file tables from the Centers for Disease Control and Prevention (CDC). On May 30, 2000, the CDC updated their 1977 weight-for-length growth charts, and introduced BMI-for-age charts and tables. The CDC explains: ''* * * (BMI) is used to judge whether an individual's weight is appropriate for their height. * * * The new BMI growth charts can be used clinically beginning at 2 years of age, when an accurate stature can be obtained. These BMI-for-age charts were created for use in place of the 1977 weight-for-stature charts, as they are considered a more accurate tool.'' (NHANES (National Health & Nutrition Examination Survey) CDC Growth Charts: United States, The Revised Growth Charts, May 30, 2000. Both the weight-for-length and BMI-for-age charts and tables are available at *http://www.cdc.gov/nchs/about/major/nhanes/growthcharts/background.htm.)*

We will prepare a Social Security Ruling containing instructions consistent with the CDC's BMI guidelines. It will be issued concurrent with publication of this material as a final rule.

In children, the CDC defines ''Underweight'' as a BMI-for-age <5th percentile. However, neither the CDC nor any other recognized expert authority has published guidelines for the classification of malnutrition based on BMI. We will continue to investigate this area. In the meantime, we propose to continue to use our current criteria of persistence of weight for length or height below the third percentile to meet listing-level severity for malnutrition.

Proposed Listing 105.09—Liver Transplant. We propose to add this new listing for children, consistent with the addition of listing 5.09—Liver transplant in the proposed adult rules. We propose that you should be considered under a disability for 12 months following the surgery, due to the nature and course of recovery for this procedure. After that time, we will evaluate the residual impairment(s). This is consistent with our criteria for assessing other organ transplants, such as kidney transplant in listing 106.02D and heart transplant in listing 104.09.

Clarity of These Proposed Rules

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

For example:

• Have we organized the material to suit your needs?

• Are the requirements in the rules clearly stated?

• Do the rules contain technical language or jargon that isn't clear?
• Would a different format (grouping and order of sections, use of headings, paragraphing) make the rules easier to understand?
• Would more (but shorter) sections be better?
• Could we improve clarity by adding tables, lists, or diagrams?
• What else could we do to make the rules easier to understand?

Regulatory Procedures

Executive Order (E.O.) 12866

We have consulted with the Office of Management and Budget (OMB) and determined that these proposed rules meet the criteria for an economically significant regulatory action under E.O. 12866. They are also a ''major'' rule under 5 U.S.C. 801ff. The following is a discussion of the potential costs and benefits of this regulatory action. This assessment also contains an analysis of alternatives we considered and chose not to adopt.

These proposed rules benefit society by updating the current listings to provide criteria that reflect state-of-the-art medical science and technology. The proposed rules ensure that determinations of disability have a sound medical basis, that claimants receive equal treatment through the use of specific criteria, and that people who are disabled can be readily identified and awarded benefits if all other factors of entitlement or eligibility are met.

We are projecting savings in program expenditures as a result of these actions, described in more detail below.

Program Savings

1. Title II

We estimate that, if finalized, these proposed rules would result in reduced program outlays resulting in the following savings (in millions of dollars) to the title II program ($295 million total in a 5-year period beginning in FY 2003).

Fiscal year:	
2003	−$5
2004	−$35
2005	−$60
2006	−$85
2007	−$110
Total	[1] −$295

2. Title XVI

We [1] estimate that, if finalized, these proposed rules will result in reduced program outlays resulting in the following savings (in millions of dollars) to the SSI program ($85 million in a 5-year period beginning in FY 2003).

Fiscal year:	
2003	−$2.5
2004	−$10
2005	−$20
2006	−$25
2007	−$30
Total	[2] −$85

Program Costs

We[2] do not expect any program costs to result from these proposed regulations.

Administrative Savings

We do not expect any administrative savings to result from these proposed regulations.

Administrative Costs

We expect that, if finalized, there will be some administrative costs associated with these proposed rules. If finalized, the proposed rules are expected to result in administrative costs less than 25 work years and less than $2 million per year.

Policy Alternatives

We considered, but did not select, the following policy alternative:

Keep the current criteria with no or only minor technical changes

We considered not revising the listings, or making only minor technical changes and thus, continuing to use our current criteria. However, we believe that proposing these revisions is preferable because of the medical advances that have been made in treating and evaluating these types of impairments. The current listings are now over 15 years old. Medical advances in disability evaluation and treatment and our program experience make clear that the current listings do not reflect state-of-the-art medical knowledge and technology.

Since there would be no changes or only minor technical changes in using this alternative, the program and administrative costs would be the same as under the current rules. However, the program savings associated with the proposed rules would not be achieved.

Regulatory Flexibility Act

We certify that these proposed rules would not have a significant economic impact on a substantial number of small entities because they would affect only individuals. Thus, a regulatory flexibility analysis as provided in the Regulatory Flexibility Act, as amended, is not required.

Paperwork Reduction Act

These proposed rules contain reporting requirements at 5.00B, 5.00D, 105.00B, and 105.00D. The public reporting burden is accounted for in the Information Collection Requests for the various forms that the public uses to submit the information to SSA. Consequently, a 1-hour placeholder burden is being assigned to the specific reporting requirement(s) contained in these rules. We are seeking clearance of the burdens referenced in these rules because they were not considered during the clearance of the forms. An Information Collection Request has been submitted to OMB. We are soliciting comments on the burden estimate; the need for the information; its practical utility; ways to enhance its quality, utility and clarity; and on ways to minimize the burden on respondents, including the use of automated collection techniques or other forms of information technology. Comments should be submitted to the Social Security Administration at the following address: Social Security Administration, Attn: SSA Reports Clearance Officer, Rm. 1–A–20 Operations Building, 6401 Security Boulevard, Baltimore, MD 21235–6401. Comments can be received for between 30 and 60 days after publication of this notice. Comments will be most useful if received by SSA within 30 days of publication.

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

List of Subjects in 20 CFR Part 404

Administrative practice and procedure, Blind, Disability benefits, Old-Age, Survivors, and Disability Insurance, Reporting and recordkeeping requirements, Social Security.

Dated: November 5, 2001.

Larry G. Massanari,

Acting Commissioner of Social Security.

For the reasons set forth in the preamble, we propose to amend chapter III of title 20 of the Code of Federal Regulations as set forth below:

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

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

Authority: Secs. 202, 205(a), (b), and (d)–(h), 216(i), 221(a) and (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

[1] 5-year total may not be equal to the sum of the annual totals due to rounding-out.

[2] Federal SSI payments due on October 1st in fiscal years 2006 and 2007 are included with payments for the prior fiscal year.

902(a)(5)); sec. 211(b), Pub. L. 104–193, 110 Stat. 2105, 2189.

2. Item 6 of the introductory text before part A of appendix 1 is amended by revising the expiration date, as follows:

Appendix 1 to Subpart P of Part 404—Listing of Impairments

* * * * *

6. Digestive System (5.00 and 105.00): [Insert date of publication of the final rules in the **Federal Register**.]

* * * * *

3. Section 5.00 in part A and section 105.00 in part B of appendix 1 are revised to read as follows:

* * * * *

5.00 Digestive System

A. What Kind of Impairments Do We Consider in the Digestive System?

1. Impairments of the digestive system include malnutrition, inflammatory bowel disease, hemorrhage, esophageal dysfunction, and hepatic (liver) dysfunction.

2. Digestive disorders may also lead to complications (*e.g.,* obstruction) or be accompanied by systemic manifestations in other body systems.

3. Surgical diversion of the intestinal tract such as colostomy and ileostomy does not usually result in an inability to perform any gainful activity, as long as you are able to maintain adequate nutrition.

4. Gastrointestinal impairments frequently respond to medical or surgical treatment and, therefore, the severity of these disorders should generally be considered within the context of prescribed treatment. This may be necessary in determining whether the duration requirement for disability will be met for cases in which you have not otherwise satisfied the duration requirement.

B. What Documentation Do We Need?

1. When we assess gastrointestinal or liver impairments, we usually need longitudinal evidence covering a period of at least 6 months of observations and treatment, unless we can make a fully favorable determination or decision without it. The evidence should include all available clinical and laboratory findings, including appropriate medically acceptable imaging studies, endoscopy, operative, and pathology reports. Criteria for documentation will be found in the individual listings.

3. You may not have received ongoing treatment or have an ongoing relationship with the medical community, despite the existence of a severe impairment(s). We evaluate such cases on the basis of the objective medical evidence and other available evidence, taking into consideration all relevant factors including your medical history, symptoms, and medical source statements. Even though you may not be able to show an impairment that meets the criteria of one of the digestive listings, you may have an impairment(s) that medically equals the listings or may be found disabled based on consideration of your residual functional capacity (RFC) and age, education, and work experience.

C. How Do We Evaluate Digestive Disorders Under Listings That Require Recurring or Persistent Findings?

1. Listings 5.02, 5.05, 5.06 and 5.08 require specific findings to be present on a recurring or persisting basis. *Recurring* means the longitudinal clinical record shows that the finding(s) satisfies the criteria in the listing as specified and that pattern has lasted or is expected to last for a continuous period of at least 12 months. *Persisting* means the longitudinal clinical record shows that, with few exceptions, the finding(s) has been at, or is expected to be at, the level specified in the listing for a continuous period of at least 12 months.

2. Events necessary to meet the listing (*e.g.,* 3 events within a consecutive 6 month period) must occur within the period we are considering in connection with an application or continuing disability review. In every listing in which we require more than one event, there must be at least 1 month between the events (unless otherwise specified), to ensure that we are evaluating separate episodes.

D. How Do We Consider the Effects of Treatment?

1. We assess the effect of treatment by determining if there is improvement in the signs, symptoms, and laboratory findings of the disorder, and if there are side effects that may result in functional limitations. We assess the effects of medication, therapy, surgery, or any other form of treatment you receive, when determining the severity and the duration of the impairment(s). The medical evidence should include:

(a) a description of the treatment prescribed (*e.g.,* the type of medication or therapy, the use of total parenteral nutrition (TPN) or enteral nutrition);

(b) dosage, method, and frequency of administration;

(c) your response to the treatment;

(d) any adverse effects of such treatment;

(e) the expected duration of the treatment.

2. Because treatment itself or the effects of treatment may be temporary, in most cases sufficient time must elapse to allow us to evaluate the impact and expected duration of treatment and side effects. Where adverse effects of treatment contribute to the impairment severity, the duration or expected duration of the treatment must be considered in assessing the duration of the impairment(s).

3. *Nutritional therapy*. The requirement for aggressive nutritional therapy, including parenteral or specialized enteral nutrition to avoid debilitating complications of a disease does not, in and of itself, indicate an inability to perform gainful activity, but should be considered, as any other treatment, in evaluation of the overall severity of the impairment.

E. How do we evaluate impairments that do not meet one of the digestive listings?

1. These listings are only examples of common digestive impairments that we consider severe enough to prevent you from doing any gainful activity. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system. For example, when liver disease results in hepatic encephalopathy, we should evaluate the impairment(s) under the criteria for the appropriate mental disorder or neurological listing(s).

2. If you have a medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals the listings. (See§§ 404.1526 and 416.926.) If your impairment(s) does not meet or medically equal the listings, you may or may not have the RFC to engage in substantial gainful activity. In that situation, we proceed to the fourth, and if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920. When we decide whether you continue to be disabled, we use the rules in §§ 404.1594 and 416.994, as appropriate.

F. What are our guidelines for evaluating specific digestive impairments?

1. Malnutrition and weight loss. Gastrointestinal disease may result in malnutrition and weight loss. In addition to the impairments specifically mentioned in the listings, other gastrointestinal disorders such as stricture, stenosis or obstruction of the esophagus may result in significant weight loss. The resulting weight loss should be evaluated under the criteria of 5.08. When using the tables in 5.08:

(a) If the reported height measured in inches falls between the whole number values, the height should be rounded off to the nearest inch by whole number (*e.g.*, if height is given as 62¼ inches, round off to 62 inches). If the fraction is precisely one-half inch, the height should be rounded up to the nearest whole number (*e.g.*, if height is given as 62½ inches, round up to 63 inches).

(b) If the reported height measured in centimeters falls evenly between two table values (*e.g.*, 151 cm falls evenly between 150 cm and 152 cm), the height should be rounded up to the nearest table value (*e.g.*, 152 cm).

(c) If the reported height measured in centimeters falls between two table values (*e.g.*, 148 cm is between 147 cm and 150 cm), the height should be rounded off to the nearest table value (*e.g.*, 147 cm).

2. Chronic liver disease is liver cell necrosis, inflammation, or scarring from any cause, that persists for more than 6 months, and is expected to continue for at least 12 months. Clinical manifestations may vary from an asymptomatic state to incapacitation due to liver failure. Acute hepatic injury is frequently reversible, as in viral, drug induced, and alcoholic hepatitis, and hepatic ischemia. In the absence of continuing evidence of a chronic impairment, episodes of acute liver disease do not necessarily meet the requirement for chronic liver disease.

(a) Signs, and symptoms of chronic liver disease often include: jaundice (yellow appearance of the skin and mucous membranes), intractable pruritis (itching), ascites (accumulation of fluid in the abdominal cavity), lower extremity edema (swelling due to large amounts of fluid), gastrointestinal bleeding, fatigue, nausea,

change in mental status and loss of appetite. Laboratory findings in cases involving liver disease may include abnormalities of liver enzymes, decreased serum albumin, increased bilirubin, abnormal coagulation studies, and abnormal liver biopsy.

(b) Liver disease may result in portal hypertension and esophageal varices, massive variceal hemorrhage, ascites, hepatic encephalopathy, and/or liver transplantation. We should assess impairment due to hepatic encephalopathy under the criteria for the appropriate mental disorder or neurological listing(s).

(c) *Massive hemorrhage from esophageal varices* typically involves hematemesis (vomiting of blood), melena (passage of dark stools), or hematochezia (passage of bloody stools). You may be hemodynamically unstable as shown by signs and symptoms such as pallor (paleness), diaphoresis (profuse perspiration), postural hypotension (fall in blood pressure when standing), and syncope (fainting). The situation can be considered life-threatening with urgent need for multiple transfusions and other supportive care.

(d) *Liver function tests* such as serum bilirubin or enzyme levels may correlate poorly with the clinical severity of liver disease, and must not be relied upon in isolation. Ascites, when associated with either albumin depletion or prolongation of the prothrombin time, usually indicates severe loss of liver function. Minimal ascites, as might be detected *only* by imaging techniques and not on physical examination, is not sufficient to meet the criteria in listing 5.05B.

(e) *Liver transplantation* may be performed for progressive liver failure, life-threatening complications of liver disease, tumor or trauma. Disability is considered to last for one year from the date of transplant. After that time, we will evaluate the residual impairment(s), as outlined in paragraph (g) below.

(f) When we use the phrase ''[c]onsider under a disability for 1 year following'' a specific event, we are making a statement about the expected duration of disability, not about the onset of disability. We do not restrict the determination of the onset of disability to the date of the specified event. We can establish an earlier onset date if you are not engaging in substantial gainful activity (SGA) and the evidence in file supports the earlier onset date of disability.

(g) After the one-year period following transplantation, we evaluate the effects of any residual impairment(s). Functional improvement after liver transplant depends upon various factors, including adequacy of post-transplant liver function, incidence and severity of infection, occurrence of rejection crisis(es), the presence of systemic complications and the side effects of immuno-suppressive agents.

5.01 Category of Impairments, Digestive System

5.02 *Recurrent gastrointestinal hemorrhage* from any cause, requiring at least two units of blood transfused per episode, and occurring at least three times during a consecutive 6-month period. (All incidents within a consecutive 14-day period constitute one episode.) Consider under a disability for 1 year following the last documented hemorrhage; thereafter, evaluate the residual impairment(s).

5.05 Chronic liver disease and cirrhosis of any kind, WITH:

A. Esophageal varices demonstrated by x-ray, endoscopy, or other appropriate medically acceptable imaging, with massive hemorrhage attributed to varices which requires a transfusion of at least 5 units of blood in 48 hours. Consider under a disability for 1 year following the last documented massive hemorrhage; thereafter, evaluate the residual impairment(s); OR

B. Ascites persisting over a consecutive 6-month period despite prescribed treatment. The following findings must be demonstrated on at least two evaluations occurring at least 2 months apart within the 6-month period:

1. Ascites documented by paracentesis; OR

2. Ascites documented on physical examination and by appropriate medically acceptable imaging with:

(a) an associated serum albumin of 3.0 gm/dl or less, or;

(b) prolongation of the prothrombin time of at least 2 seconds over the control.

5.06 *Inflammatory bowel disease* (*e.g.*, ulcerative colitis, Crohn's disease) as documented by endoscopy, biopsy, appropriate medically acceptable imaging, or operative findings, with persistent or recurrent intestinal obstruction over a consecutive 6-month period, despite prescribed treatment, WITH:

A. Confirmation, by appropriate medically acceptable imaging, of stenotic areas in small intestine or colon with proximal dilatation, and;

B. Documentation of at least two episodes of abdominal pain, distention, and vomiting.

5.08 *Weight loss due to any persisting gastrointestinal disorder,* with weight equal to or less than the values specified in Table I or II, persistent for at least 6 consecutive months despite prescribed treatment, and expected to persist at this level for at least 12 consecutive months.

TABLE I.—MEN

Height	Weight
Inches/centimeters	Pounds/kilograms
61 in./155 cm	103 lbs/47 kg
62 in./158 cm	105 lbs/48 kg
63 in./160 cm	106 lbs/48 kg
64 in./163 cm	108 lbs/49 kg
65 in./165 cm	110 lbs/50 kg
66 in./168 cm	111 lbs/51 kg
67 in./170 cm	114 lbs/52 kg
68 in./173 cm	116 lbs/53 kg
69 in./175 cm	118 lbs/54 kg
70 in./178 cm	121 lbs/55 kg
71 in./180 cm	123 lbs/56 kg
72 in./183 cm	126 lbs/57 kg
73 in./185 cm	128 lbs/58 kg
74 in./188 cm	131 lbs/60 kg
75 in./191 cm	134 lbs/61 kg
76 in./193 cm	137 lbs/62 kg

TABLE II.—WOMEN

Height	Weight
Inches/centimeters	Pounds/kilograms
58 in./147 cm	87 lbs/40 kg
59 in./150 cm	89 lbs/40 kg
60 in./152 cm	90 lbs/41 kg
61 in./155 cm	92 lbs/42 kg
62 in./158 cm	94 lbs/43 kg
63 in./160 cm	97 lbs/44 kg
64 in./163 cm	99 lbs/45 kg
65 in./165 cm	102 lbs/46 kg
66 in./168 cm	104 lbs/47 kg
67 in./170 cm	106 lbs/48 kg
68 in./173 cm	109 lbs/49 kg
69 in./175 cm	111 lbs/50 kg
70 in./178 cm	114 lbs/52 kg
71 in./180 cm	116 lbs/53 kg
72 in./183 cm	118 lbs/54 kg
73 in./185 cm	121 lbs/55 kg

5.09 *Liver transplant.* Consider under a disability for 1 year following surgery. Thereafter, evaluate the residual impairment (see 5.00F2e.)

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Part B

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105.00 DIGESTIVE SYSTEM

A. What kind of impairments do we consider in the digestive system?

1. Impairments of the digestive system include malnutrition, inflammatory bowel disease, hemorrhage, esophageal dysfunction, and hepatic (liver) dysfunction.

2. Digestive disorders may also lead to complications (*e.g.,* obstruction) or be accompanied by systemic manifestations in other body systems.

3. Congenital defects involving the organs of the gastrointestinal system may result in your inability to maintain adequate nutrition, growth and development.

4. Surgical diversion of the intestinal tract such as colostomy and ileostomy does not usually result in marked and severe functional limitations, as long as you are able to maintain adequate nutrition, growth and development.

5. Gastrointestinal impairments frequently respond to medical or surgical treatment, and, therefore, the severity of these disorders should generally be considered within the context of prescribed treatment. This may be necessary in determining whether the duration requirement for disability will be met for cases in which you have not already otherwise satisfied the duration requirement.

B. What documentation do we need?

1. When we assess gastrointestinal or liver impairments, we usually need longitudinal evidence covering a period of at least 6 months of observations and treatment, unless we can make a fully favorable determination or decision without it. The evidence should include all available clinical findings, including assessment(s) of growth and development, as well as all laboratory findings, including operative, appropriate medically acceptable imaging studies, endoscopy, and pathology reports. Criteria

for documentation will be found in the individual listings.

2. You may not have received ongoing treatment or have an ongoing relationship with the medical community, despite the existence of a severe impairment(s). We evaluate such cases on the basis of the objective medical evidence and other available evidence, taking into consideration all relevant factors (see §§ 416.924, 416.924a, and 416.924b) including your medical history, symptoms, and medical source statements. Even though you may not be able to show an impairment that meets the criteria of one of the digestive listings, you may have an impairment(s) medically equivalent in severity to one of the listed impairments or, as appropriate, may be disabled based on functionally equaling the listings (See §§ 404.1526, 416.926, and 416.926a.).

C. How do we evaluate digestive disorders under listings that require recurring or persistent findings?

1. Listings 105.05, 105.06 and 105.08 require specific findings to be present on a recurring or persisting basis. *Recurring* means the longitudinal clinical record shows that the finding(s) satisfies the criteria in the listing as specified and that pattern has lasted or is expected to last for a continuous period of at least 12 months. *Persisting* means the longitudinal clinical record shows that, with few exceptions, the finding(s) has been at, or is expected to be at, the level specified in the listing for a continuous period of at least 12 months.

2. Events necessary to meet the listing (*e.g.,* 3 events within a consecutive 6-month period) must occur within the period we are considering in connection with an application or continuing disability review. In every listing in which we require more than one event, there must be at least 1 month between the events (unless otherwise specified), to ensure that we are evaluating separate episodes.

D. How do we consider the effects of treatment?

1. We assess the effect of treatment by determining if there is improvement in the symptoms, signs, and laboratory findings of the disorder, and if there are side effects that may result in functional limitations. We assess the effects of medication, therapy, surgery, or any other form of treatment you receive, when determining the severity and the duration of the impairment(s). The medical evidence should include:

(a) a description of the treatment prescribed (*e.g.,* the type of medication or therapy, the use of total parenteral nutrition (TPN) or enteral nutrition);

(b) dosage, method, and frequency of administration;

(c) your response to the treatment;

(d) any adverse effects of such treatment;

(e) the expected duration of the treatment.

2. Because treatment itself or the effects of treatment may be temporary, in most cases sufficient time must elapse to allow us to evaluate the impact and expected duration of treatment and side effects. Where adverse effects of treatment contribute to the impairment severity, the duration or expected duration of the treatment must be considered in assessing the duration of the impairment(s).

3. *Nutritional therapy.* The requirement for aggressive nutritional therapy, including parenteral or specialized enteral nutrition to avoid debilitating complications of a disease does not, in and of itself, indicate marked and severe functional limitations, but should be considered, as any other treatment, in evaluation of the overall severity of the impairment.

E. How Do We Evaluate Impairments That Do Not Meet One of the Digestive Listings?

1. These listings are only examples of common digestive impairments that we consider severe enough to result in marked and severe functional limitations. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system. For example:

(a) *When liver disease results in hepatic encephalopathy or hepatic coma,* we should evaluate your impairment(s) under the criteria for the appropriate mental disorder or neurological listing(s).

(b) *If you have multiple congenital anomalies,* you should be evaluated under the criteria for the multiple body system listings (section 110.00) or the criteria for other appropriate body system(s).

(c) *Digestive impairments that interfere with intake, digestion, and/or absorption of nutrition,* may result in a reduction in the rate of growth. If such a reduction is not reflected in the malnutrition listing (105.08), it may be necessary to refer to the growth impairment listings for further evaluation of the impairment.

2. If you haves a medically determinable impairment(s) that does not meet a listing, we will determine whether the impairment(s) medically equals the listings, or, in the case of a claim for SSI payments under Title XVI, functionally equals the listings. (See §§ 404.1526, 416.926, and 416.926a.) When we decide whether you continue to be disabled under Title XVI, we use the rules in § 416.994a.

F. What Are Our Guidelines For Evaluating Specific Digestive Impairments?

1. *Malnutrition, weight loss and growth retardation.*

(a) *Chronic nutritional deficiency.* Gastrointestinal disease may result in malnutrition. The resulting weight loss or growth retardation, or both, should be considered under the criteria of 105.08 and, if necessary, section 100.00 (growth impairments) of the listings. To meet the criteria in 105.08, the malnutrition must be documented with a laboratory finding(s) confirming a chronic nutritional deficiency associated with a gastrointestinal impairment, which exists despite prescribed treatment. Such findings include, but are not limited to, the following:

(1) Severe anemia (hemoglobin less than 8);

(2) Serum albumin less than 3.0 Gm/Del;

(3) Intractable steatorrhea, despite enzyme therapy, with fecal fat excretion more than:

15% of fat intake in infants less than 6 months; OR

10% of fat intake in infants 6–18 months; OR

6% of fat intake in children more than 18 months of age.);

(4) Vitamin, mineral, or trace mineral deficiency despite aggressive medical and nutritional therapy.

(b) *Body Mass Index (BMI).* BMI is the ratio of your weight to the square of your height. According to the Centers for Disease Control and Prevention (CDC), it is the recommended measure to determine if your weight is appropriate for your height beginning at 2 years of age. Prior to age 2, the CDC's weight-for-length charts should be used. A BMI-for-age less than the 5th percentile indicates underweight; a BMI-for-age less than the 3rd percentile satisfies our criteria for malnutrition when due to a demonstrable gastrointestinal or other impairment.

2. Chronic liver disease is liver cell necrosis, inflammation, or scarring from any cause, that persists for more than 6 months, and is expected to continue for at least 12 months. Clinical manifestations may vary from an asymptomatic state to incapacitation due to liver failure. Acute hepatic injury is frequently reversible as in viral, drug-induced, and alcoholic hepatitis, and hepatic ischemia. In the absence of continuing evidence of a chronic impairment, episodes of acute liver disease do not necessarily meet the requirement for chronic liver disease.

(a) Signs and symptoms of chronic liver disease often include: jaundice (yellow appearance of the skin and mucous membranes), intractable pruritis (itching), ascites, lower extremity edema (swelling due to large amounts of fluid), gastrointestinal bleeding, fatigue, nausea, change in mental status and loss of appetite. Laboratory findings in cases involving liver disease may include abnormalities of liver enzymes, decreased serum albumin, increased bilirubin, abnormal coagulation studies, and abnormal liver biopsy.

(b) Liver disease may result in portal hypertension, bleeding from esophageal varices, ascites, hepatic encephalopathy, hepatic coma, and/or liver transplantation. We should assess impairment due to hepatic encephalopathy and hepatic coma under the criteria for the appropriate mental disorder or neurological listing(s).

(c) Chronic liver disease in children may cause portal hypertension that precedes or seems out of proportion to the severity of hepatocellular injury. You may have chronic recurrent variceal bleeding, cholestasis (stoppage or suppression of the flow of bile), and/or ascites (accumulation of fluid in the abdominal cavity) well before other features of liver failure.

(d) *Massive hemorrhage from esophageal varices* typically involves hematemesis (vomiting of blood), melena (passage of dark stools), or hematochezia (passage of bloody stools). You may be hemodynamically unstable as shown by signs and symptoms such as pallor (paleness), diaphoresis (profuse perspiration), postural hypotension (fall in blood pressure when standing), and syncope (fainting). The situation can be life-threatening with urgent need for multiple transfusions and other supportive care.

(e) *Liver function tests* such as serum bilirubin or enzyme levels may correlate

poorly with the clinical severity of liver disease, and must not be relied upon in isolation. Ascites, when associated with either albumin depletion or prolongation of the prothrombin time, usually indicates severe loss of liver function. However, persistent ascites related to chronic liver disease is an impairment of listing-level severity in children, regardless of serum albumin level. Minimal ascites, as might be detected *only* by imaging techniques and not on physical examination, is not sufficient to meet the criteria in 105.05B.

(f) *Liver transplantation* may be performed for progressive liver failure, life-threatening complications of liver disease, tumor or trauma. Disability is considered to last for one year from the date of the transplant. After that time, we will evaluate your residual impairment(s), as outlined in paragraph (h) below.

(g) When we use the phrase ''[c]onsider under a disability for 1 year following'' a specific event, we are making a statement about the expected duration of disability, not about the onset of disability. We do not restrict the determination of disability onset to the date of the specified event. We can establish an earlier onset date if you are not engaging in substantial gainful activity (SGA) and the evidence in file supports the earlier onset date of disability.

(h) After the one year period following transplantation, we evaluate the effects of any residual impairment(s). Functional improvement after liver transplant depends upon various factors, including adequacy of post-transplant liver function, incidence and severity of infection, occurrence of rejection crisis(es), the presence of systemic complications and the side effects of immuno-suppressive agents. Growth and development may also be affected.

3. Esophageal stricture or stenosis (narrowing) from congenital atresia (absence or closure of a normal body tubular organ) or destructive esophagitis may meet the criteria for malnutrition in listing 105.08. It also may result in complications that include respiratory impairments due to frequent aspiration, problems maintaining nutritional status short of listing-level severity, or multiple infections such as pneumonia. While none of these complications may be of a severity or persistence to meet the criteria of another specific listing, the combination may result in marked and severe functional limitations.

4. Inflammatory bowel disease under listing 105.06B. requires an intractable perineal or intra-abdominal complication such as intractable fecal incontinence. Intractable is defined as resistant to cure, relief or control. There must be evidence of surgical or medical therapy that has failed to resolve the complication. Fecal incontinence involves passage of actual fecal material, not mere staining or spotting.

105.00 Category of Impairments, Digestive System

105.05 Chronic liver disease and cirrhosis of any kind

WITH:

A. Esophageal varices demonstrated by x-ray, endoscopy, or other appropriate medically acceptable imaging, with at least three episodes of bleeding requiring transfusion due to hemodynamic instability, occurring over a consecutive 6-month period. Episodes must be separated by at least 1 month. Consider under a disability for 1 year following last episode; thereafter, evaluate the residual impairment(s); or

B. Ascites persisting over a consecutive 6-month period despite prescribed treatment. The following findings must be demonstrated on at least two evaluations occurring at least 2 months apart within the 6-month period:

1. Ascites documented by paracentesis; OR

2. Ascites documented on physical examination and by appropriate medically acceptable imaging.

105.06 *Inflammatory bowel disease* (*e.g.,* ulcerative colitis, Crohn's disease) as documented by endoscopy, biopsy, appropriate medically acceptable imaging, or operative findings WITH:

A. Persistent or recurrent intestinal obstruction over a consecutive six-month period, despite prescribed treatment, WITH:

(1) Confirmation, by appropriate medically acceptable imaging, of stenotic areas in small intestine or colon with proximal dilatation, and;

(2) documentation of at least two episodes of abdominal pain, distention, and vomiting; OR

B. Perineal or intra-abdominal complications such as abscess, fistuli or fecal incontinence; intractable despite medical or surgical treatment; clinically documented over a consecutive 6-month period.

105.08 *Malnutrition,* despite prescribed treatment, due to gastrointestinal, hepatobiliary, or pancreatic disease with a documented sign of chronic nutritional deficiency, meeting one of the following:

A. For children under age 2, weight-for-length less than the 3rd percentile on the CDC's weight-for-length growth charts or data files, documented at least three times over a consecutive 6-month period, and expected to persist for at least 12 months; OR

B. For children age 2 and over, Body Mass Index (BMI) for age less than the 3rd percentile on the CDC's BMI-for-age growth charts or data files, documented at least three times over a consecutive 6-month period, and expected to persist for at least 12 months.

105.09 *Liver transplant.* Consider under a disability for 1 year following surgery. Thereafter, evaluate the residual impairment(s) (see 105.00F2e.)

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[FR Doc. 01–28455 Filed 11–13–01; 8:45 am]

BILLING CODE 4191–02–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG–137519–01]

RIN 1545–BA09

Consolidated Returns; Applicability of Other Provisions of Law; Non-Applicability of Section 357(c)

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rule-making and notice of public hearing.

SUMMARY: This document proposes amendments relating to the consolidated return regulations dealing with the non-applicability of section 357(c) in a consolidated group. The proposed amendments clarify that, in certain transfers described in section 351 between members of a consolidated group, a transferee's assumption of certain liabilities described in section 357(c)(3) will not reduce the transferor's basis in the transferee's stock received in the transfer. This document also provides notice of a public hearing on these proposed regulations.

DATES: Written or electronic comments and requests to speak (with outlines of oral comments to be discussed) at the public hearing scheduled for March 21, 2002, must be submitted by February 28, 2002.

ADDRESSES: Send submissions to: CC:ITA:RU (REG–137519–01), room 5226, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand delivered Monday through Friday between the hours of 8 a.m. and 5 p.m. to: CC:ITA:RU (REG–137519–01), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC. Alternatively, taxpayers may submit comments electronically via the internet by selecting the ''Tax Regs'' option on the IRS Home Page, or by submitting comments directly to the IRS internet site at *http://www.irs.gov/tax_regs/reglist.html.* The public hearing will be held in room 4718, Internal Revenue Building, 1111 Constitution Avenue, NW., Washington, DC.

FOR FURTHER INFORMATION CONTACT: Concerning the regulations, T. Ian Russell of the Office of Associate Chief Counsel (Corporate), (202) 622–7930; concerning submissions, the hearing, and/or to be placed on the building access list to attend the hearing, Donna M. Poindexter (202–622–7180) (not toll-free numbers).