By the Commission.

Jill M. Peterson,

Assistant Secretary.

[FR Doc. 2014–07523 Filed 4–1–14; 4:15 pm]

BILLING CODE 8011–01–P

SMALL BUSINESS ADMINISTRATION

Small Business Investment Companies—Early Stage SBICs

AGENCY: U.S. Small Business Administration.

ACTION: Notice; Extension of deadlines for Early Stage fund managers.

SUMMARY: On February 4, 2014, the U.S. Small Business Administration (''SBA'') published a Call for Early Stage Fund Managers (the ''Call'') in the **Federal Register** to submit the preliminary materials discussed in Section II of the Call for consideration to be licensed as Early Stage Small Business Investment Companies (''SBICs''). As set forth in the **DATES** section below, this notice modifies the current deadlines for the submission of such materials, as well as the dates for various steps in the Early Stage SBIC licensing process.

DATES: The deadlines for material requested in the SBA notice published on February 4, 2014 (79 FR 6664) are modified. The following table provides the modified dates for the Early Stage SBIC Initiative.

Milestones	Dates/times
Question and Answer Period Closes	5 p.m. Eastern Time (''ET'') on May 16, 2014.
Initial Review Period	
Management Assessment Questionnaires (''MAQs'') Due	5 p.m. ET–May 16, 2014.
Interview Period	June 30, 2014–July 8, 2014.
Anticipated Greenlight Decision	June 30, 2014–July 8, 2014.
Licensing Periods	
For funds with $20M of Regulatory Capital seeking a license in FY 2014	5 p.m. ET July 31, 2014.
Anticipated Licensing Date for FY 2014 funds	September 30, 2014.
All other funds have 12 months from issuance of a Greenlight to submit their license application.	Applications considered as they are received.

Notes:

- *SBA reserves the right to extend its interview, due diligence, committee, and approval timelines, as appropriate. SBA will update its Web site at www.sba.gov/inv/earlystage should these dates change. Applicants will be notified by e-mail should these dates change.*
- *SBA expects to issue additional calls for Early Stage Fund Managers on an annual basis. SBA will announce these calls via a call notice in theFederal Register.*

ADDRESSES: Visit *www.sba.gov/inv/MAQ* to download a copy of the Management Assessment Questionnaire (the ''MAQ''). You must submit via express or next day delivery service (i) the relevant MAQ signature pages and (ii) the completed MAQ on a CD–ROM in *Word* and *Excel* format to the following: Scott Schaefer, Senior Investment Officer, Office of Investment and Innovation, U.S. Small Business Administration, 409 3rd St. SW., Suite #6300, Washington, DC 20416.

SBA will not accept MAQs in .pdf format or MAQs delivered via (i) regular mail due to irradiation requirements, or (ii) hand delivery or courier service.

SUPPLEMENTARY INFORMATION: The Early Stage SBIC Initiative is part of President Obama's ''Start-Up America Initiative'' to promote American innovation and job creation by encouraging private sector investment in job-creating startups and small firms, accelerating research, and addressing barriers to success for entrepreneurs and small businesses. By licensing and providing SBA guaranteed leverage to Early Stage SBICs, SBA seeks to expand entrepreneurs' access to capital and encourage innovation. More information on the Early Stage SBIC Initiative and the regulations governing these SBICs may be found at *www.sba.gov/inv/earlystage*.

For further information, refer to the Call for Early Stage Fund Managers, published in the **Federal Register** at 79 FR 6664 (February 4, 2014).

Pravina Raghavan,

Deputy Associate Administrator, Office of Investment and Innovation.

[FR Doc. 2014–07303 Filed 4–2–14; 8:45 am]

BILLING CODE 8025–01–P

SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2013–0060]

Social Security Ruling, SSR 14–1p; Titles II and XVI: Evaluating Claims Involving Chronic Fatigue Syndrome (CFS)

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are providing notice of SSR 14–1p. This SSR provides guidance on how we develop evidence to establish that a person has a medically determinable impairment of chronic fatigue syndrome and how we evaluate chronic fatigue syndrome in disability claims and continuing disability reviews under titles II and XVI of the Social Security Act.

DATES: *Effective Date:* April 3, 2014.

FOR FURTHER INFORMATION CONTACT: Cheryl A. Williams, Office of Medical Listings Improvement, Social Security Administration, 6401 Security Boulevard, Baltimore, Maryland 21235–6401, (410) 965–1020.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so in accordance with 20 CFR 402.35(b)(1).

Through SSRs, we convey to the public, precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, and special veterans benefits programs. We may base SSRs on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or regulations, they are binding on all components of the Social Security Administration. 20 CFR 402.35(b)(1).

This SSR will remain in effect until we publish a notice in the **Federal Register** that rescinds it, or we publish a new SSR that replaces or modifies it.

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

Dated: March 27, 2014.

Carolyn W. Colvin,

Acting Commissioner of Social Security.

POLICY INTERPRETATION RULING

TITLES II AND XVI: EVALUATING CASES INVOLVING CHRONIC FATIGUE SYNDROME (CFS)

This Social Security Ruling (SSR) rescinds and replaces SSR 99–2p: ''Titles II and XVI: Evaluating Cases Involving Chronic Fatigue Syndrome (CFS).''

PURPOSE: This SSR clarifies our policy on how we develop evidence to establish that a person has a medically determinable impairment (MDI) of CFS and how we evaluate this impairment in disability claims and continuing disability reviews under titles II and XVI the Social Security Act (Act).[1]

CITATIONS: Sections 216(i), 223(d), 223(f), 1614(a)(3) and 1614(a)(4) of the Social Security Act, as amended; Regulations No. 4, subpart P, sections 404.1502, 404.1505, 404.1508–404.1513, 404.1519a, 404.1520, 404.1520a, 404.1521, 404.1523, 404.1526–404.1529, 404.1545, 404.1560–404.1569a, 404.1593, 404.1594, appendices 1 and 2; and Regulations No. 16, subpart I, sections 416.902, 416.905, 416.906, 416.908–416.913, 416.919a, 416.920, 416.920a, 416.921, 416.923, 416.924, 416.924a, 416.926, 416.926a, 416.927–416.929, 416.945, 416.960–416–969a, 416.987, 416.993, 416.994, and 416.994a.

INTRODUCTION:

CFS is a systemic disorder consisting of a complex of symptoms that may vary in frequency, duration, and severity. In 1994, an international panel convened by the Centers for Disease Control and Prevention (CDC) developed a case definition for CFS that serves as an identification tool and research definition.[2] In 2003, an expert subcommittee of Health Canada, the Canadian health agency, convened a consensus workshop that developed a clinical case definition for CFS, known as the Canadian Consensus Criteria (CCC).[3] In 2011, a private international group developed guidelines, known as the International Consensus Criteria (ICC),[4] for diagnosing myalgic encephalomyelitis (ME).[5] Members of this international group and other medical experts consider ME to be a subtype of CFS.[6] We adapted the CDC criteria, and to some extent the CCC and ICC, when we formulated the criteria in this SSR.[7]

We consider a person to be ''disabled'' [8] if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) [9] which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. We require that an MDI result from anatomical, physiological, or psychological abnormalities, as shown by medically acceptable clinical and laboratory diagnostic techniques.[10] The Act and our regulations further require that the impairment be established by medical evidence that consists of signs, symptoms, and laboratory findings; therefore, a claimant may not be found disabled on the basis of a person's statement of symptoms alone.[11] In this SSR, we explain that CFS, when accompanied by appropriate medical signs or laboratory findings, is an MDI that can be the basis for a finding of ''disability.'' We also explain how we evaluate CFS claims.

POLICY INTERPRETATION

CFS constitutes an MDI when accompanied by medical signs or laboratory findings, as discussed below. CFS may be a disabling impairment. This policy interpretation clarifies how our adjudicators should apply our regulations in determining whether a person claiming benefits based on CFS is disabled under titles II and XVI the Act. Adults and children may claim these benefits. As mentioned, we include ME as a subtype of CFS. When we refer to CFS in this SSR, we include ME.

I. What is CFS?

CFS is a systemic disorder that may vary in frequency, duration, and severity. CFS can occur in children,[12] particularly adolescents, as well as in adults.

The CDC and other medical experts characterize CFS, in part, as a syndrome that causes prolonged fatigue lasting 6 months or more, resulting in a substantial reduction in previous levels of occupational, educational, social, or personal activities. In accordance with the CDC case definition of CFS, a physician should make a diagnosis of CFS ''only after alternative medical and psychiatric causes of chronic fatiguing illness have been excluded.'' [13]

A. *General.* Under the CDC case definition, the hallmark of CFS is the presence of clinically evaluated, persistent or relapsing chronic fatigue that:

1. Is of new or definite onset (that is, has not been lifelong);
2. Cannot be explained by another physical or mental disorder;
3. Is not the result of ongoing exertion;
4. Is not substantially alleviated by rest; and
5. Results in substantial reduction in previous levels of occupational, educational, social, or personal activities.

B. *Additional indications of CFS.* CFS results in additional symptoms, some more common than others.

1. *Diagnostic Symptoms.* The CDC case definition requires the concurrence of 4 or more specific symptoms that persisted or recurred during 6 or more consecutive months of illness and did not pre-date the fatigue:

- Postexertional malaise lasting more than 24 hours (which may be the most common secondary symptom);
- Self-reported impairment(s) in short-term memory or concentration severe enough to cause substantial reduction in previous

[1] For simplicity, we refer in this SSR only to initial adult claims for disability benefits under titles II and XVI of the Act and to the steps of the sequential evaluation process we use to determine disability in those claims. 20 CFR 404.1520 and 416.920. The policy interpretations in this SSR apply to all cases in which we must make determinations about disability, including claims of children (that is, people who have not attained age 18) who apply for benefits based on disability under title XVI of the Act, disability redeterminations for children who became eligible for Supplemental Security Income under title XVI as a child and who were eligible for such benefits for the month before the month in which they attained age 18, and to continuing disability reviews of adults and children under titles II and XVI of the Act. 20 CFR 404.1594, 416.924, 416.987, 416.994, and 416.994a.

[2] See Center for Disease Control and Prevention, ''Chronic Fatigue Syndrome (CFS),'' available at: *http://www.cdc.gov/cfs.*

[3] See Carruthers, B.M., et al. Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: Clinical Working Case Definition, Diagnostic and Treatment Protocols, *Journal of Chronic Fatigue Syndrome,* Jan; 11(1), 7–36 (2003); see also, *Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: A Clinical Case Definition and Guidelines for Medical Practitioners,* Canada: Carruthers & van de Sande, 2005 (available at: *http://sacfs.asn.au/download/consensus_overview_me_cfs.pdf).*

[4] See Carruthers, B.M., et al. Myalgic Encephalomyelitis: International Consensus Criteria, *Journal of Internal Medicine,* Apr; 270(4), 327–338 (2011); also, Carruthers, B.M. & van de Sande, M.I.,eds., *Myalgic Encephalomyelitis—Adult & Pediatric: International Consensus Primer for Medical Practitioners,* Canada: Carruthers & van de Sande, 2012 (available at: *http://sacfs.asn.au/download/me_international_consensus_primer_for_medical_practitioners.pdf).*

[5] Although the panel that developed the ICC considers its criteria appropriate for diagnosing only ME, we consider the ICC helpful in establishing an MDI of CFS because of the similarities between CFS and ME. For example, ME also is a systemic disorder that manifests many of the same symptoms as CFS, including prolonged fatigue.

[6] Medical experts who consider ME to be a subtype of CFS may use hybrid terms to describe the syndrome, such as CFS/ME and ME/CFS.

[7] We adapted the CDC criteria, CCC, and ICC because the Act and our regulations require a claimant to establish by objective medical evidence that he or she has a medically determinable impairment. See 223(d)(5)(A) and 1614(a)(3)(D) of the Act, 20 CFR 404.1058 and 416.908, and SSR 96–4p: Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations, 61 FR 34488 (1996) (also available at *http://www.ba.ssa.gov/OP_Home/rulings/di/01/SSR96–04-di-01.html.*

[8] Except for statutory blindness.

[9] We use the term ''impairment(s)'' in this SSR to refer to an ''impairment or a combination of impairments.''

[10] See sections 223(d)(3) and 1614(a)(3)(D) of the Act, and 20 CFR 404.1508 and 416.908.

[11] See sections 223(d)(5)(A) and 1614(a)(3)(D) of the Act; 20 CFR 404.1508 and 416.908; and SSR 96–4p.

[12] In children, symptoms may progress more gradually than in adolescents or adults.

[13] See Fukuda, K. et al. The Chronic Fatigue Syndrome: A Comprehensive Approach to a Definition and Study, *Annals of Internal Medicine,* Dec. 121(12), 953–9596 (1994).

levels of occupational, educational, social, or personal activities; [14]

- Sore throat;
- Tender cervical or axillary lymph nodes;
- Muscle pain;
- Multi-joint pain without joint swelling or redness;
- Headaches of a new type, pattern, or severity; and
- Waking unrefreshed.[15]

2. *Other Symptoms.* Within these parameters, the CDC case definition, CCC, and ICC describe a wide range of other symptoms a person with CFS may exhibit: [16]

- Muscle weakness;
- Disturbed sleep patterns (for example, insomnia, prolonged sleeping, frequent awakenings, or vivid dreams or nightmares);
- Visual difficulties (for example, trouble focusing, impaired depth perception, severe photosensitivity, or eye pain);
- Orthostatic intolerance (for example, lightheadedness, fainting, dizziness, or increased fatigue with prolonged standing);
- Respiratory difficulties (for example, labored breathing or sudden breathlessness);
- Cardiovascular abnormalities (for example, palpitations with or without cardiac arrhythmias);
- Gastrointestinal discomfort (for example, nausea, bloating, or abdominal pain); and
- Urinary or bladder problems (for example, urinary frequency, nocturia, dysuria, or pain in the bladder region).

3. *Co-occurring Conditions.* People with CFS may have co-occurring conditions, such as fibromyalgia (FM),[17] myofascial pain syndrome, temporomandibular joint syndrome, irritable bowel syndrome, interstitial cystitis,[18] Raynaud's phenomenon, migraines, chronic lymphocytic thyroiditis, or Sjogren's syndrome. Co-occurring conditions may also include new allergies or sensitivities to foods, odors, chemicals, medications, noise, vibrations, or touch, or the loss of thermostatic stability (for example, chills, night sweats, or intolerance of extreme temperatures).

II. How does a person establish an MDI of CFS?

A. General.

1. A person can establish that he or she has an MDI of CFS by providing appropriate evidence from an acceptable medical source.[19] A licensed physician (a medical or osteopathic doctor) is the only acceptable medical source who can provide such evidence. We cannot rely upon the physician's diagnosis alone. The evidence must document that the physician reviewed the person's medical history and conducted a physical exam. We will review the physician's treatment notes to see if they are consistent with the diagnosis of CFS; determine whether the person's symptoms have improved, worsened, or remained stable; and establish the physician's assessment of the person's physical strength and functional abilities.

2. We will find that a person has an MDI of CFS if a licensed physician diagnosed CFS, and this diagnosis is not inconsistent with the other evidence in the person's case record. Under the CDC case definition, a physician can make the diagnosis of CFS based on a person's reported symptoms alone after ruling out other possible causes for the person's symptoms.[20] However, as mentioned, statutory and regulatory provisions require that, for evaluation of claims of disability under the Act, there must also be medical signs or laboratory findings before we may find that a person has an MDI of CFS. If we cannot find that the person has an MDI of CFS but there is evidence of another MDI, we will not evaluate the impairment under this SSR. Instead, we will evaluate it under the rules that apply for that impairment.

B. *Medical signs.* For the purposes of Social Security disability evaluation, one or more of the following medical signs clinically documented over a period of at least 6 consecutive months help establish the existence of an MDI of CFS:

- Palpably swollen or tender lymph nodes on physical examination;
- Nonexudative pharyngitis;
- Persistent, reproducible muscle tenderness on repeated examinations, including the presence of positive tender points; [21] or
- Any other medical signs that are consistent with medically accepted clinical practice and are consistent with the other evidence in the case record. For example, the CCC and ICC explain that an acute infectious inflammatory event may precede the onset of CFS, and that other medical signs may be present, including the following:
  - Frequent viral infections with prolonged recovery;
  - Sinusitis;
  - Ataxia;
  - Extreme pallor; and
  - Pronounced weight change.

C. *Laboratory findings.* At this time, we cannot identify specific laboratory findings that are widely accepted as being associated with CFS. However, the absence of a definitive test does not preclude our reliance upon certain laboratory findings to establish the existence of an MDI in people with CFS. While standard laboratory test results in the normal range are characteristic for many people with CFS, and they should not be relied upon to the exclusion of all other clinical evidence in decisions regarding the presence and severity of an MDI, the following laboratory findings establish the existence of an MDI in people with CFS:

- An elevated antibody titer to Epstein-Barr virus (EBV) capsid antigen equal to or greater than 1:5120, or early antigen equal to or greater than 1:640;
- An abnormal magnetic resonance imaging (MRI) brain scan;
- Neurally mediated hypotension as shown by tilt table testing or another clinically accepted form of testing; or
- Any other laboratory findings that are consistent with medically accepted clinical practice and are consistent with the other evidence in the case record (for example, an abnormal exercise stress test or abnormal sleep studies, appropriately evaluated and consistent with the other evidence in the case record).

D. *Additional signs and laboratory findings.* Because of the ongoing research into the etiology and manifestations of CFS, the medical criteria discussed above are only examples of physical and mental signs and laboratory findings that can help us establish the existence of an MDI; they are not all-inclusive. As medical research advances regarding CFS, we may discover additional signs and laboratory findings to establish that people have an MDI of CFS. For example, scientific studies now suggest there may be subsets of CFS with different causes, including viruses such as Human Herpesvirus 6. Thus, we may document the existence of CFS with medical signs and laboratory findings other than those listed above provided such evidence is consistent with medically accepted clinical practice, and is consistent with the other evidence in the case record.

E. *Mental limitations.* Some people with CFS report ongoing problems with short-term memory, information processing, visual-spatial difficulties, comprehension, concentration, speech, word-finding, calculation, and other symptoms suggesting persistent neurocognitive impairment. When ongoing deficits in these areas have been documented by mental status examination or

[14] We may consider self-reported impairments in short-term memory or concentration to be symptoms of CFS. As we explain in section IIE, when these impairments are documented by mental status examination or psychological testing, we may also consider them to be medical signs or laboratory findings.

[15] "Waking unrefreshed" may be shown in the case record by a person's reports that describe a history of non-restorative sleep, such as statements about waking up tired or having difficulty remaining awake during the day, or other statements or evidence in the record reflecting that the person has a history of non-restorative sleep.

[16] In addition, generalized pain and neurological symptoms (for example, headaches, cognitive impairments, sleep disturbance, and dyslexia evident when fatigued) may be common in children and adolescents. Episodes of intense postexertional weakness may occur, eventually causing a previously active child to reduce or avoid physical activity.

[17] See SSR 12–2p: Titles II and XVI: Evaluation of Fibromyalgia, 77 FR 43640(2012)(also available at: *http://www.ssa.gov/OP_Home/rulings/di/01/SSR2012–02-di-01.html).*

[18] See SSR 02–2p: Titles II and XVI: Evaluation of Interstitial Cystitis, 67 FR 67436 (2002) (also available at: *http://www.ssa.gov/OP_Home/rulings/di/01/SSR2002–02-di-01.html).*

[19] See 20 CFR 404.1513(a) and 416.913(a).

[20] Some examples of other disorders that may have symptoms that are the same or similar to those resulting from CFS include Addison's disease, Cushing's syndrome, hypothyroidism, iron deficiency, B12 deficiency, iron overload syndrome, diabetes mellitus, cancer, upper airway resistance syndrome, sleep apnea, rheumatologic disorders, multiple sclerosis, Parkinsonism, myasthenia gravis, Lyme disease, and chronic hepatitis.

[21] There is considerable overlap of symptoms between CFS and FM, but people with CFS who also have tender points have an MDI. People with impairments that fulfill the American College of Rheumatology criteria for FM (which includes a minimum number of tender points) may also fulfill the criteria for CFS. See SSR 12–2p. However, we may still find that a person with CFS has an MDI if he or she does not have the specified number of tender points to establish FM.

psychological testing, such findings may constitute medical signs or (in the case of psychological testing) laboratory findings that establish the presence of an MDI.[22] When medical signs or laboratory findings suggest a persistent neurological impairment or other mental problems, and these signs or findings are appropriately documented in the medical record, we may find that the person has an MDI.

III. How do we document CFS?

A. *General.* In cases in which CFS is alleged, we generally need longitudinal evidence because medical signs, symptoms, and laboratory findings of CFS fluctuate in frequency and severity and often continue over a period of many months or years.

1. Longitudinal clinical records reflecting ongoing medical evaluation and treatment from the person's medical sources, especially treating sources, are extremely helpful in documenting the presence of any medical signs or laboratory findings, as well as the person's functional status over time. The longitudinal record should contain detailed medical observations, information about treatment, the person's response to treatment, and a detailed description of how the impairment limits the person's ability to function.

2. In addition to obtaining evidence from a physician, we may request evidence from other acceptable medical sources, such as psychologists, both to determine whether the person has another MDI(s) and to evaluate the severity and functional effects of CFS or any of the person's other impairments. Under our regulations and SSR 06–03p, we also may consider evidence from medical sources we do not consider ''acceptable medical sources'' to help us evaluate the severity and functional effects of the impairment(s).[23]

3. We may also consider information from nonmedical sources.[24] This information may also help us assess the person's ability to function day-to-day and over time. It may also assist us in assessing the person's allegations about symptoms and their effects (see section IV below). Examples of nonmedical sources include:

- Spouses, parents, siblings, other relatives, neighbors, friends, and clergy;
- Past employers, rehabilitation counselors, and teachers; and
- Statements from SSA personnel who interviewed the person.

4. Before we make a determination that you are not disabled, we will make every reasonable effort to develop your complete medical history and help you get medical reports from your own medical sources. Generally, we will request evidence from your medical sources for the 12-month period preceding the month of application unless there is reason to believe that development of an earlier period is necessary, or unless the alleged onset of disability is less than 12 months before the date of application.[25]

5. When the alleged onset of disability secondary to CFS occurred less than 12 months before adjudication, we must evaluate the medical evidence and project the degree of impairment severity that is likely to exist at the end of 12 months.[26] Information about the person's treatment and response to treatment, as well as any medical source opinions about the person's prognosis at the end of 12 months, helps us decide whether to expect the MDI to be of disabling severity for at least 12 consecutive months.

B. *How do we consider medical opinions about a person's impairment?* We consider the nature of the treatment relationship between the medical source[27] and the claimant when we evaluate the source's medical opinions about a person's impairment(s). If we find that a treating source's medical opinion regarding the nature and severity of a person's impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques, and the opinion is not inconsistent with the other substantial evidence in the case record, we will give it controlling weight.[28] If a medical source states that a person is ''disabled'' or ''unable to work,'' or provides an opinion on issues such as whether an impairment(s) meets or is equivalent in severity to the requirements of a listing, a person's residual functional capacity (RFC), or the application of vocational factors, we consider these statements to be opinions on issues reserved to the Commissioner. We must still consider such opinions in adjudicating a disability claim; however, we will not give any special significance to such an opinion because of its source.[29]

C. *Resolving conflicts.* Conflicting evidence in the medical record is not unusual in cases of CFS due to the complicated diagnostic process involved. We may seek clarification of any such conflicts in the medical evidence first from the person's treating or other medical sources, in accordance with our rules.

D. *What do we do if there is insufficient evidence to determine whether the person has an MDI of CFS or is disabled?*

1. When there is insufficient evidence for us to determine whether the person has an MDI of CFS or is disabled, we may take one or more actions to try to resolve the insufficiency:[30]

- We may recontact the person's treating or other source(s) to see if the information we need is available;
- We may request additional existing records;
- We may ask the person or others for more information; or
- We may purchase a consultative examination (CE) at our expense.[31]

2. When we are unable to resolve an insufficiency in the evidence, and we need to determine whether the person has an MDI of CFS or is disabled, we may make a determination or decision based on the evidence we have.[32]

IV. *How do we evaluate a person's statements about his or her symptoms and functional limitations?*

Generally, we follow a two-step process:

A. *First step of the symptom-evaluation process.* There must be medical signs and findings that show the person has an MDI(s) which we could reasonably expect to produce the fatigue or other symptoms alleged.[33] If we find that a person has an MDI that we could reasonably expect to produce the alleged symptoms, the first step of our two-step process for evaluating symptoms is satisfied.

B. *Second step of the symptom-evaluation process.* After finding that the MDI could reasonably be expected to produce the alleged symptoms, we evaluate the intensity and persistence of the person's symptoms and determine the extent to which they limit the person's capacity for work. If objective medical evidence does not substantiate the person's statements about the intensity, persistence, and functionally limiting effects of symptoms, we consider all of the evidence in the case record, including the person's daily activities; medications or other treatments the person uses, or has used, to alleviate symptoms; the nature and frequency of the person's attempts to obtain medical treatment for symptoms; and statements by other people about the person's symptoms. We will make a finding about the credibility of the person's statements regarding the effects of his or her symptoms on functioning.[34] When we need additional

[22] See 20 CFR 404.1528 and 416.928.

[23] See 20 CFR 404.1513(d)(4), 416.913(d)(4); and SSR 06–03p: Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not ''Acceptable Medical Sources'' in Disability Claims, 71 FR 45593 (2006) (also available at: *http://www.ssa.gov/OP_Home/rulings/di/01/SSR2006-03-di-01.html).*

[24] See SSR 06–03p.

[25] See 20 CFR 404.1512(d)(2) and 416.912(d) concerning situations in which we would develop an earlier period.

[26] To meet the statutory requirement for ''disability,'' a person must have been unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which is expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. See 42 U.S.C. 423(d)(1) and 1382c(a)(3)(A). Thus, the existence of an impairment(s) for 12 continuous months is not controlling; rather, it is the existence of a disabling impairment which has lasted or can be expected to last for at least 12 months that meets the duration requirement of the Act.

[27] See 20 CFR 404.1502 and 416.902 for the definitions of ''medical source'' and ''treating source.''

[28] See 20 CFR 404.1527(c)(2) and 416.927(c)(2); SSR 96–2p, Titles II and XVI: Giving Controlling Weight to Treating Source/Medical Opinions, 61 FR 34492 (2006) (also available at: *http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR96-02-di-01.html)*

[29] See SSR 96–5p, Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner, 61 FR 34471 (1996) (also available at: *http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR96-05-di-01.html).*

[30] See 20 CFR 404.1520b(c) and 416.920b(c).

[31] See 20 CFR 404.1520b(c)(3) and 416.920b(c)(3). The type of CE we purchase will depend on the nature of the person's symptoms and the extent of the evidence already in the case record. We may purchase a CE without recontacting a person's treating or other source if the source cannot provide the necessary information, or the information is not available from the source. See 20 CFR 404.1519a(b) and 416.919a(b).

[32] See 20 CFR 404.1520b(d) and 416.920b(d).

[33] See 20 CFR 404.1529(b) and 416.929(b).

[34] See SSR 96–7p: Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the

Continued

information to assess the credibility of the individual's statements about symptoms and their effects, we will make every reasonable effort to obtain available information that could shed light on the credibility of the person's statements.

V. How do we find a person disabled based on an MDI of CFS?

Once we establish that a person has an MDI of CFS, we will consider this MDI in the sequential evaluation process to determine whether the person is disabled.[35] As we explain in section VI below, we consider the severity of the impairment, whether the impairment medically equals the requirements of a listed impairment, and whether the impairment prevents the person from doing his or her past relevant work or other work that exists in significant numbers in the national economy.

VI. How do we consider CFS in the sequential evaluation process?

We adjudicate claims involving CFS using the sequential evaluation process, just as we do for any impairment. Once we find that an MDI(s) exists (see section II), we must establish the severity of the impairment(s). We determine the severity of a person's impairment(s) based on the totality of medical signs, symptoms, and laboratory findings, and the effects of the impairment(s), including any related symptoms, on the person's ability to function. Additionally, several other disorders (including, but not limited to FM, multiple chemical sensitivity, and Gulf War Syndrome, as well as various forms of depression, and some neurological and psychological disorders) may share characteristics similar to those of CFS. When there is evidence of the potential presence of another disorder that may adequately explain the person's symptoms, it may be necessary to pursue additional medical or other development. As mentioned, if we cannot find that the person has an MDI of CFS but there is evidence of another MDI, we will not evaluate the impairment under this SSR. Instead, we will evaluate it under the rules that apply for that impairment.

A. *Step 1.* We consider the person's work activity. If a person with CFS is doing substantial gainful activity, we find that he or she is not disabled.

B. *Step 2.* If we establish that a person has an MDI that meets the duration requirement,[36] and the person alleges fatigue, pain, symptoms of neurocognitive problems, or other symptoms consistent with CFS, we must consider these symptoms in deciding whether the person's impairment is ''severe'' in step 2 of the sequential evaluation process, and at any later steps reached in the sequential evaluation process. If we find fatigue, pain, neurocognitive symptoms, or other symptoms cause a limitation or restriction, and they have more than a minimal effect on a person's ability to perform basic work activities, we must find that the person has a ''severe'' impairment.[37]

C. *Step 3.* When we find that a person has a severe MDI, we must proceed with the sequential evaluation process and next consider whether the person's impairment is of the severity contemplated by the Listing of Impairments.[38] CFS is not a listed impairment; therefore, we cannot find that a person with CFS alone has an impairment that meets the requirements of a listed impairment. However, we will compare the specific findings in each case to any pertinent listing (for example, listing 14.06B in the listing for repeated manifestations of undifferentiated or mixed connective tissue disease) to determine whether medical equivalence may exist.[39] Further, in cases in which a person with CFS has psychological manifestations related to CFS, we must consider whether the person's impairment meets or equals the severity of any impairment in the mental disorders listings.[40]

D. *Steps 4 and 5.* For those impairments that do not meet or equal the severity of a listing, we must make an assessment of the person's RFC. After we make our RFC assessment, our evaluation must proceed to the fourth step of the sequential evaluation process, if we do not use an expedited process.[41] If necessary, we then proceed to the fifth step of the sequential evaluation process.[42] In assessing RFC, we must consider all of the person's impairment-related symptoms in deciding how such symptoms may affect functional capacities.[43] The RFC assessment must be based on all the relevant evidence in the record.[44] If we do not use an expedited process, we must determine that the person's impairment(s) precludes the performance of past relevant work (or if there was no past relevant work). If we determine that the person's impairment precludes performance of past relevant work, we must make a finding about the person's ability to perform other work.[45] We must apply the usual vocational considerations in determining the person's ability to perform other work.[46]

E. *Continuing disability reviews.* In those cases in which we find that a person is disabled based on CFS, we will schedule an appropriate continuing disability review.[47] For this review, we take into account relevant individual case facts, such as the combined severity of other chronic or static impairments and the person's vocational factors.

EFFECTIVE DATE: This SSR is effective on April 3, 2014.

CROSS-REFERENCES: SSR 82–63: Titles II and XVI: Medical-Vocational Profiles Showing an Inability To Make an Adjustment to Other Work; SSR 83–12: Title II and XVI: Capability To Do Other Work—The Medical-Vocational Rules as a Framework for Evaluating Exertional Limitations Within a Range of Work or Between Ranges of Work; SSR 83–14: Titles II and XVI: Capability To Do Other Work—The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments; SSR 85–15: Titles II and XVI: Capability To Do Other Work—The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments; SSR 96–2p, Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions; SSR 96–3p, Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment is Severe; SSR 96–4p, Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations; SSR 96–5p, Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner; SSR 96–7p, Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements; SSR 96–8p, Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims; SSR 96–9p, Titles II and XVI: Determining Capability to Do Other Work—Implications of a Residual Functional Capacity for Less Than a Full Range of Sedentary Work; SSR 02–2p, Titles II and XVI: Evaluation of Interstitial Cystitis; SSR 06–03p, Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not ''Acceptable Medical Sources'' in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies; SSR 11–2p, Titles II and XVI: Documenting and Evaluating Disability in Young Adults; SSR 12–2p, Titles II and XVI: Evaluation of Fibromyalgia; and Program Operations Manual System (POMS) DI 22505.001, DI 22505.003, DI 24505.003, DI 24510.057, DI 24515.012, DI 24515.061–DI 24515.063, DI 24515.066–DI 24515.067, DI 24515.075, DI 24555.001, DI 25010.001, and DI 25025.001.

[FR Doc. 2014–07465 Filed 4–2–14; 8:45 am]

BILLING CODE 4191–02–P

Credibility of an Individual's Statements, 61 FR 34483 (1996) (also available at: *http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR96-07-di-01.html).*

[35] See 20 CFR 404.1520, 416.920 and 416.924.

[36] See 20 CFR 404.1509 and 416.909.

[37] See SSR 96–3p: Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment Is Severe, 61 FR 34468 (1996) (also available at: *http://www.ssa.gov/OP_Home/rulings/di/01/SSR96-03-di-01.html).*

[38] See 20 CFR 404, subpart P, appendix 1.

[39] In evaluating title XVI claims for disability benefits for people under age 18, we will consider whether the impairment(s) functionally equals the listings. See 20 CFR 416.926a.

[40] See sections 12.00 and 112.00 of 20 CFR part 404, subpart P, appendix 1.

[41] See 404.1520(h) and 416.920(h).

[42] The fourth and fifth steps of the sequential evaluation process are not applicable to claims for benefits under title XVI for people under age 18. See 20 CFR 416.924.

[43] See 404.1529(d) and 416.929(d), and SSR 96–7p.

[44] See 20 CFR 404.1545(a) and 416.945(a).

[45] See SSR 96–8p: Titles II and XVI: Assessing Residual Functional Capacity in Initial claims, 61 FR 34474 (1996) (also available at *http://www.ba.ssa.gov/OP_Home/rulings/di/01/SSR96-08-di-01.html.*

[46] See 20 CFR 404.1560–404.1569a and 416.960–416.969a, and SSR 11–2p: Titles II and XVI: Documenting and Evaluating Disability in Young Adults, 76 FR 56263 (2011) (also available at *http://www.ba.ssa.gov/OP_Home/rulings/di/01/SSR2011-02-di-01.html).*

[47] See 20 CFR 404.1593, 404.1594, 404.1579, 416.993, 416.994 and 416.994a.