B–4 [Revised]

From Utopia Creek, AK, NDB; Evansville, AK, NDB; to Yukon River, AK, NDB.

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Paragraph 6009(b) Red Federal Airways

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R–4 [New]

From Chena, AK, NDB; to Bear Creek, AK, NDB

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R–50 [Revised]

From Nanwak, AK, NDB; via Oscarville, AK, NDB; Anvik, AK, NDB.

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Paragraph 6009(a) Green Federal Airways

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G–7 [Revised]

From Gambell, AK, NDB; Fort Davis, AK, NDB; Norton Bay, AK, NDB

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Issued in Washington, DC on February 22, 2006.

Edith V. Parish,

Manager, Airspace and Rules.

[FR Doc. 06–1913 Filed 2–28–06; 8:45 am]

BILLING CODE 4910–13–P

SOCIAL SECURITY ADMINISTRATION

20 CFR Parts 404 and 416

RIN 0960–AF19

Evidentiary Requirements for Making Findings About Medical Equivalence

AGENCY: Social Security Administration.

ACTION: Final rules.

SUMMARY: We are revising our regulations that pertain to the processing of claims for disability benefits under title II and title XVI of the Social Security Act (the Act). These revisions make the language in the rules we use under title II of the Act for making findings about medical equivalence consistent with the language in the rules that we use under title XVI of the Act. These revisions also clarify our rules about the evidence we use when we make findings about medical equivalence for adults and children. We are also updating and clarifying our rules that explain the Listing of Impairments (the listings) and how your impairment(s) can meet a listing.

DATES: These rules will be effective on March 31, 2006.

Electronic Version

The electronic file of this document is available on the date of publication in the **Federal Register** at *http://www.gpoaccess.gov/fr/index.html.*

FOR FURTHER INFORMATION CONTACT: Suzanne DiMarino, Social Insurance Specialist, Office of Regulations, Social Security Administration, 107 Altmeyer Building, 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, Social Security Online, at *http://www.socialsecurity.gov.*

SUPPLEMENTARY INFORMATION: We are revising our regulations that explain how we make findings about whether your impairment(s) medically equals a listing. Since February 11, 1997, § 416.926, our regulation for making findings about medical equivalence under title XVI, included different language from § 404.1526, our regulation about medical equivalence under title II. We are now updating § 404.1526 so that it is the same as § 416.926.

As we discuss in more detail below, we are also clarifying language in our regulations that was at issue in the decision in *Hickman* v. *Apfel,* 187 F.3d 683 (7th Cir. 1999), about the evidence we consider when we make findings about medical equivalence. Because these final rules clarify our regulatory policy that was at issue in Hickman, we are also rescinding Acquiescence Ruling (AR) 00–2(7), which we issued in response to the court's decision under the authority of §§ 404.985(e)(4) and 416.1485(e)(4) of our regulations concurrently with the effective date of these final rules.

In addition, we are updating and clarifying our rules in §§ 404.1525 and 416.925. As we explain below, the changes are not substantive.

We are also making minor editorial changes throughout §§ 404.1525, 404.1526, 416.925, and 416.926, as well as conforming changes in other regulations to reflect the changes we are making in these sections.

What Programs Do These Regulations Affect?

These regulations affect disability determinations and decisions that we make under title II and title XVI of the Act. In addition, to the extent that Medicare entitlement and Medicaid eligibility are based on whether you qualify for disability benefits under title II or title XVI, these final regulations 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 (see § 404.336) of insured workers.

Under title XVI of the Act, we provide for Supplemental Security Income (SSI) payments on the basis of disability if you are disabled and 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 is expected to result in death or which has lasted or is 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 impairments(s) as described above that results in * * *
Title II	An adult or child	The inability to do any substantial gainful activity (SGA).
Title XVI	A person age 18 or older	The inability to do any SGA.
Title XVI	A person under age 18	Marked and severe functional limitations.

How Do We Decide Whether You Are Disabled?

If you are seeking benefits under title II of the Act, or if you are an adult seeking benefits under title XVI of the Act, we use a five-step ''sequential evaluation process'' to decide whether you are disabled. We describe this five-step process in our regulations at §§ 404.1520 and 416.920. We follow the five steps in order and stop as soon as we can make a determination or decision. The steps are:

1. Are you working, and is the work you are doing substantial gainful activity? If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled, regardless of your medical condition or your age, education, and work experience. If you are not, we will go on to step 2.

2. Do you have a ''severe'' impairment? If you do not have an impairment or combination of impairments that significantly limits your physical or mental ability to do basic work activities, we will find that you are not disabled. If you do, we will go on to step 3.

3. Do you have an impairment(s) that meets or medically equals the severity of an impairment in the listings? If you do, and the impairment(s) meets the duration requirement, we will find that you are disabled. If you do not, we will go on to step 4.

4. Do you have the residual functional capacity to do your past relevant work? If you do, we will find that you are not disabled. If you do not, we will go on to step 5.

5. Does your impairment(s) prevent you from doing any other work that exists in significant numbers in the national economy, considering your residual functional capacity, age, education, and work experience? If it does, and it meets the duration requirement, we will find that you are disabled. If it does not, we will find that you are not disabled.

We use a different sequential evaluation process for children who apply for payments based on disability under SSI. If you are already receiving benefits, we also use a different sequential evaluation process when we decide whether your disability continues. See §§ 404.1594, 416.924, 416.994, and 416.994a of our regulations. However, all of these processes include steps at which we consider whether your impairment(s) meets or medically equals one of our listings.

What Are the Listings?

The listings are examples of impairments that we consider severe enough to prevent you as an adult from doing any gainful activity. If you are a child seeking SSI payments based on disability, the listings describe impairments that we consider severe enough to result in marked and severe functional limitations. Although the listings are contained only in appendix 1 to subpart P of part 404 of our regulations, we incorporate them by reference in the SSI program in § 416.925 of our regulations, and apply them to claims under both title II and title XVI of the Act.

How Do We Use the Listings?

The listings are in two parts. There are listings for adults (part A) and for children (part B). If you are a person age 18 or over, we apply the listings in part A when we assess your claim, and we never use the listings in part B.

If you are a person under age 18, we first use the criteria in part B of the listings. If the listings in part B 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. (See §§ 404.1525 and 416.925.) If your impairment(s) does not meet any listing, we will consider whether it medically equals any listing; that is, whether it is as medically severe. (See §§ 404.1526 and 416.926.)

What If You Do Not Have An Impairment(s) That Meets or Medically Equals a Listing?

We use the listings only to decide that you are disabled or that you are still disabled. We will never deny your claim or decide that you no longer qualify for benefits because your impairment(s) does not meet or medically equal a listing. If you have a severe impairment(s) that does not meet or medically equal any listing, we may still find you disabled based on other rules in the ''sequential evaluation process.'' Likewise, we will not decide that your disability has ended only because your impairment(s) does not meet or medically equal a listing.

Also, when we conduct reviews to determine whether your disability continues, we will not find that your disability has ended because we have changed a listing. Our regulations explain that, when we change our listings, we continue to use our prior listings when we review your case, if you qualified for disability benefits or SSI payments based on our determination or decision that your impairment(s) met or medically equaled a listing. 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 condition(s) has medically improved, so that you no longer meet or medically 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 §§ 404.1594(c)(3)(i) and 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(s). See § 416.994a(b)(2).

What Do We Mean by ''Final Rules'' and ''Prior Rules''?

Even though these rules will not go into effect until 30 days after publication of this notice, for clarity, we refer to the changes we are making here as the ''final rules'' and to the rules that will be changed by these final rules as the ''prior rules.''

Why Are We Revising Our Evidentiary Requirements for Making Findings About Medical Equivalence?

Prior §§ 404.1526 and 416.926 did not contain the same language because of changes we made to § 416.926 in final rules that we published on February 11, 1997. On that date, we published interim final rules to implement the childhood disability provisions of Public Law 104–193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The rules became effective on April 14, 1997 (62 FR 6408).

Before April 14, 1997, §§ 404.1526 and 416.926 were essentially identical, with only minor differences specific to titles II and XVI. However, § 416.926 applied only to adults; our rules for evaluating medical equivalence for children under the SSI program were in § 416.926a of our regulations, along with our policies about functional equivalence in children. In the interim final rules that became effective on April 14, 1997, we moved the rules for medical equivalence in children into the same section as the rules for medical equivalence in adults, reserving § 416.926a solely for functional equivalence.

Before April 14, 1997, we provided more detailed rules for determining medical equivalence for children in § 416.926a than in the corresponding rules for determining medical equivalence for adults in §§ 404.1526 and 416.926. We adopted this language

in our childhood regulations from internal operating instructions about medical equivalence that we applied to all individuals. When we revised § 416.926 in 1997, we decided to use the more detailed rules for both children and adults. We explained in the preamble to the interim final rules that:

> [w]e decided to use the provisions of former § 416.926a(b) to explain our rules for determining medical equivalence for both adults and children. This is not a substantive change, but a clearer statement of our longstanding policy on medical equivalence than was previously included in prior § 416.926(a), as it was clarified for children in prior § 416.926a(b). This merely allows us to address only once in our regulations the policy of medical equivalence, which is and always has been the same for adults and children.

62 FR at 6413.

While we did not revise § 404.1526 when we revised § 416.926 in 1997, we also recognized that there was no substantive difference between the two rules. We noted in the preamble that ''[a]lthough some of the text of [§ 416.926(a)] will differ from the text of § 404.1526(a), both sections * * * will continue to provide the same substantive rules.'' 62 FR at 6413. Since we did not revise § 404.1526 when we published the interim final rules for evaluating disability in children, we also did not revise it when we published final rules in 2000. 65 FR 54747, 54768 (2000). We are now revising prior § 404.1526 so that it includes the same language as § 416.926.

In addition, we are making minor revisions to the language in our rules on medical equivalence to clarify that we consider all information that is relevant to our finding about whether your impairment(s) medically equals the criteria of a listing. In *Hickman* v. *Apfel*, 187 F.3d 683 (7th Cir. 1999), the Court of Appeals interpreted our statement in prior § 416.926(b) that ''[w]e will always base our decision about whether your impairment(s) is medically equal to a listed impairment on medical evidence only'' differently from what we intended. The *Hickman* court held that this provision meant that we could use evidence only from medical sources when we made findings about medical equivalence. However, we intended the phrase ''medical evidence only'' in the prior regulation section only to exclude consideration of the vocational factors of age, education, and work experience, as defined in a number of our other regulations. See, for example, §§ 404.1501(g), 404.1505, 404.1520(g), 404.1560(c)(1), 416.901(j), 416.905, 416.920(g), and 416.960(c)(1) of our regulations. Under our interpretation of our regulations, the phrase ''medical evidence'' included not just findings reported by medical sources but other information about your medical condition(s) and its effects, including your own description of your impairment(s).

The *Hickman* court believed that when we amended the regulations in 1997 to add § 416.926(b) we added a rule that ''explicitly eliminates any recourse to non-medical evidence.'' *Hickman*, 187 F.3d at 688. However, as we have already noted in the above quotes from the preamble to the 1997 interim final regulations, we stated in that preamble that this was not our intent. Thus, the court's decision interpreted the language of our regulations more narrowly than we intended.

Because of this, we issued AR 00–2(7) to implement the Court of Appeals' holding within the States in the Seventh Circuit. 65 FR 25783 (2000). In the AR, we stated that we intended to clarify the language at issue in *Hickman* at §§ 404.1526 and 416.926 through the issuance of a regulatory change and that we might rescind the AR once we clarified the regulations. 65 FR at 25785. Likewise, when we published the final rules for evaluating disability in children on September 11, 2000, we indicated in response to comments that we planned to revise § 404.1526 to clarify this issue in response to *Hickman*. 65 FR at 54768. We are now revising §§ 404.1526 and 416.926 to clarify our longstanding interpretation of the regulations in response to the *Hickman* decision. As we have already noted, we are also publishing a separate notice rescinding AR 00–2(7) effective on the same date that these rules become effective.

When Will We Start To Use These Final Rules?

We will start to use these final rules on their effective date. We will continue to use our prior rules until the effective date of these final rules. When the final rules become effective, we will apply them to new applications filed on or after the effective date of these rules and to claims pending before us, as we describe below.

As is our usual practice when we make changes to our regulations, we will apply these final rules on or after their effective date when we make a determination or decision, including those claims in which we make a determination or decision after remand to us from a Federal court. With respect to claims in which we have made a final decision, and that are pending judicial review in Federal court, we expect that the court's review of the Commissioner's final decision would be made in accordance with the rules in effect at the time of the administrative law judge's (ALJ) decision, if the ALJ's decision is the final decision of the Commissioner. If the court determines that the Commissioner's final decision is not supported by substantial evidence, or contains an error of law, we would expect that the court would reverse the final decision, and remand the case for further administrative proceedings pursuant to the fourth sentence of section 205(g) of the Act, except in those few instances in which the court determines that it is appropriate to reverse the final decision and award benefits without remanding the case for further administrative proceedings. In those cases decided by a court after the effective date of the rules, where the court reverses the Commissioner's final decision and remands the case for further administrative proceedings, on remand, we will apply the provisions of these final rules to the entire period at issue in the claim.

What Revisions Are We Making?

Section 404.1526 Medical Equivalence

Section 416.926 Medical Equivalence for Adults and Children

We are revising §§ 404.1526 and 416.926 so that they use the same language. We are also revising these sections to clarify that we consider all relevant evidence in your case record when we make a finding about whether your impairment or combination of impairments medically equals a listing. The specific revisions are as follows.

We are replacing all of the headings with questions, revising text to put it into active voice and to use simpler language where possible, and reorganizing text and providing more subparagraphs for ease of reading.

Final §§ 404.1526(a) and 416.926(a)—''What is medical equivalence?''—correspond to the first sentence of prior § 416.926(a)—''How medical equivalence is determined.'' They provide a basic definition of medical equivalence.

Final §§ 404.1526(b) and 416.926(b)—''How do we determine medical equivalence?''—correspond to the last sentence of prior § 416.926(a) and the provisions of prior §§ 416.926(a)(1) and (a)(2). Throughout these sections, we have removed the word ''medical'' from the phrase ''medical findings'' in the prior rules to help clarify that we consider all relevant information when we determine whether your

impairment(s) medically equals the requirements of a listing.

We are also adding new §§ 404.1526(b)(4) and 416.926(b)(4) to provide cross-references to §§ 404.1529(d)(3) and 416.929(d)(3). Those sections explain how we consider symptoms when we make findings about medical equivalence.

Final §§ 404.1526(c) and 416.926(c)—''What evidence do we consider when we determine if your impairment(s) medically equals a listing?''—correspond to prior §§ 404.1526(b) and 416.926(b) and the third sentence of prior § 416.926(a). In these sections, we clarify that we consider all evidence in your case record about your impairment(s) and its effects on you that is relevant to our finding whether your impairment(s) medically equals a listing. We also explain that this means only that we do not consider your vocational factors of age, education, and work experience. The last sentence of final §§ 404.1526(c) and 416.926(c) corresponds to the last sentence of prior §§ 404.1526(b) and 416.926(b). We are making minor editorial changes to the language of that sentence, including the deletion of the word ''medical'' from the phrase ''medical opinion'' that was in the prior rules. Under §§ 404.1527(a) and 416.927(a) of our regulations, the term ''medical opinion'' has a specific meaning that does not include opinions about medical equivalence. This change only updates the language of §§ 404.1526(b) and 416.926(b) to match our other rules.

Because we are adding new §§ 404.1526(c) and 416.926(c), we are redesignating prior §§ 404.1526(c) and 416.926(c) as §§ 404.1526(d) and 416.926(d). These paragraphs explain who we consider to be designated medical and psychological consultants for purposes of determining medical equivalence. We are making only a minor editorial correction to the heading of prior paragraph (c) (final paragraph (d)): the addition of a question mark.

We are also redesignating prior § 416.926(d) as § 416.926(e) because of the addition of new final § 416.926(c). This paragraph explains who is responsible for determining medical equivalence at each level of the administrative review process. In addition, we are making a minor correction to the second sentence to reflect our current organization. The prior sentence referred to ''the Associate Commissioner for Disability.'' This reference is out of date because we no longer have an organization called the Office of Disability. The appropriate reference is now to ''the Associate Commissioner for Disability Determinations.'' For an explanation of the reorganization that resulted in this change, see 67 FR 69287 (November 15, 2002). (For similar reasons, we are replacing the title ''Director of the Office of Disability Hearings'' with the title ''Associate Commissioner for Disability Determinations'' in a number of our rules in subpart J of part 404 and subpart N of part 416 to update those rules as well.) We are also making a minor revision in the heading of final § 416.926(e).

Prior § 404.1526 did not include a provision analogous to prior § 416.926(d) (final § 416.926(e)), so we are adding § 404.1526(e) to make § 404.1526 the same as final § 416.926.

What Other Revisions Are We Making?

Section 404.1525 Listing of Impairments in Appendix 1

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

We are updating and clarifying these sections, which describe the listings and how we use them. As in final §§ 404.1526 and 416.926, we are replacing all of the headings with questions, deleting the word ''medical'' from the phrase ''medical criteria,'' revising text to put it into active voice and into simpler language where possible, and reorganizing text and providing more subparagraphs for ease of reading. We are also explaining better how we organize listings sections and providing an explanation of what it means to ''meet'' a listing.

We are also updating our descriptions of the part B listings to reflect the current listings. As we explain below, some of the prior provisions regarding the part B listings dated back to 1977 and no longer accurately described the content of those listings. Finally, we are moving the provisions on symptoms as they pertain to meeting the listings to §§ 404.1529 and 416.929, our rules on evaluating symptoms, and deleting a provision that was unnecessary because it was redundant.

The following is a summary of the major changes we are making in final §§ 404.1525 and 416.925.

We are moving the discussion of duration in the last two sentences of prior §§ 404.1525(a) and 416.925(a) to final §§ 404.1525(c) and 416.925(c), where we discuss how we use the listings.

Final §§ 404.1525(b) and 416.925(b)—''How is appendix 1 organized?''—correspond to prior §§ 404.1525(b) and 416.925(b). They explain that the listings are in two parts: part A, which is primarily for adults, and part B, which is only for children. In paragraph (b)(2), the paragraph that describes part B of the listings, we are deleting language from the prior rule that was out of date and no longer necessary.

When we originally published the part B listings for children in 1977, we intended them to supplement the part A listings. In the preamble to the publication of the part B listings, we explained that we originally developed the part A listings primarily for determining disability in adults. We indicated that a number of the listings for adults at that time were appropriate for evaluating disability in children too, but that there were also some listings that were not appropriate because certain listed impairments had different effects in children. We also noted that there were some diseases and other impairments in young children that were not addressed in the adult listings. Therefore, we published the part B listings, which we referred to as ''additional criteria.'' See 42 FR 14705 (March 16, 1977). The regulation at that time stated:

> Part B is used where the criteria in Part A do not give appropriate consideration to the particular effects of disease processes in childhood; i.e., when the disease process is generally found only in children or when the disease process differs in its effect on children than on adults. Where additional criteria are included in Part B, the impairment categories are, to the extent feasible, numbered to maintain a relationship with their counterparts in Part A. The method for adjudicating claims for children under age 18 is to look first to Part B. Where the medical criteria in Part B are not applicable, the medical criteria in Part A should be used.

20 CFR 416.906 (1977). (In 1977, we published the childhood listings and the regulation that explained them only in subpart I of part 416 of our regulations. In 1980, we changed to the current version of our rules, in which we publish both the child and adult listings only in appendix 1 of subpart P of part 404 of our regulations and provide explanations of the listings in both §§ 404.1525 and 416.925. (45 FR 55566, August 20, 1980.))

With minor editorial changes, the corresponding language of the rules in prior §§ 404.1525(b)(2) and 416.925(b)(2) was essentially the same as the language that we first published. However, since we originally published the listings, we have greatly expanded the childhood listings in part B so that it is no longer appropriate to speak of them as a supplement to the part A listings. To the contrary, the part B listings are for the most part stand-

alone; that is, in addition to listings that are specifically for children, and with relatively few exceptions, they include the same listings as part A when those listings are applicable to both adults and children. Although it is still appropriate in claims of children to refer to certain listings in part A when the part B listings do not apply, the current relationship of part A to part B is the opposite of what it was when we first published the part B listings in 1977. For children, the primary listings are in part B, and we may use certain part A listings in addition to the part B listings.

We believe that the language in the first three sentences of prior §§ 404.1525(b)(2) and 416.925(b)(2) was not only out of date but also unnecessary. We first published it (and the part B listings) to provide rules for adjudicating claims of children under the SSI program when that program was still relatively young. Rules explaining the relationship between part A and the new part B were helpful in those early years, but we believe that we do not need this kind of explanation in our regulations anymore. They do not provide rules for adjudication or guidelines for our adjudicators to follow when they determine disability in children under the listings, and we do not believe that they provide information that is especially helpful to public understanding of our rules.

Therefore, we are deleting most of the language in the first three sentences of prior §§ 404.1525(b)(2) and 416.925(b)(2). We are clarifying in the third sentence of final §§ 404.1525(b)(2) and 416.925(b)(2)(i) that, if the criteria in part B do not apply, we may use the criteria in part A when those criteria give appropriate consideration to the effects of the impairment(s) in children. This is a more accurate statement of how we now use the part A listings in childhood claims. In the fourth sentence of the final rules, we are retaining the provision in the third sentence of the prior rules that explains that, to the extent possible, we number the provisions in part B to maintain a relationship with part A. We are retaining this statement in our rules because there are still some body systems in part B in which the listings are not numbered consecutively because of this relationship, and this provision will continue to answer questions about why some listings in part B are not consecutively numbered.

In the prior rules, § 416.925(b)(2) was longer than § 404.1525(b)(2). This was because the paragraph in part 416 included rules about our definition of the phrase ''listing-level severity,'' which we use when we evaluate claims of children seeking SSI payments based on disability under title XVI of the Act. We are not making any substantive changes to this language, but we are making minor editorial changes in final § 416.925(b)(2)(ii). None of these revisions, which are set forth in the bullets below, is a substantive change from the prior rules.

- First, because the prior paragraph was long, we are dividing it into two subparagraphs. Final § 416.925(b)(2)(i) is the same as final § 404.1525(b)(2). Final § 416.925(b)(2)(ii) contains the provisions unique to part 416 that started with the sixth sentence of prior § 416.925(b)(2).
- Second, the prior section referred to both ''domains of functioning'' and ''broad areas of functioning.'' These terms are synonymous in our rules; however, we currently use the phrase ''domains of functioning'' more frequently. Therefore, in the final rules, we are changing the phrase ''broad areas of functioning'' to ''domains of functioning'' for consistency of language within the rules.
- Third, in the prior rules, we inadvertently referred inconsistently to both ''extreme *limitations*'' and ''extreme *limitation*'' in a domain as a standard of listing-level severity. We are correcting this inconsistency by changing the word ''limitations'' to ''limitation'' consistent with the standards in our other rules; see, for example, § 416.926a(a).
- Finally, we are deleting a duplicate cross-reference to § 416.926a. We inadvertently included the same parenthetical cross-reference to the definitions of the terms ''marked'' and ''extreme'' in the seventh and ninth sentences of prior § 416.925(b). We are deleting the second reference.

Final §§ 404.1525(c) and 416.925(c)—''How do we use the listings?''—correspond to prior §§ 404.1525(c) and 416.925(c). We are breaking up the prior paragraph into shorter subparagraphs and making editorial changes for clarity. In the second sentence of final §§ 404.1525(c)(2) and 416.925(c)(2), we are expanding and clarifying the second sentence of prior §§ 404.1525(c) and 416.925(c). The final rules clarify that we sometimes provide information in the introductory section of each body system that is necessary to show whether your impairment meets the criteria of a particular listing, not just to establish a diagnosis or the existence of a medically determinable impairment. For example, to meet most musculoskeletal listings, you must show that you have either an ''inability to ambulate effectively'' or an ''inability to perform fine and gross movements effectively.'' We define these severity terms from the individual musculoskeletal listings in the introductory text of the musculoskeletal body system, in section 1.00B2 for adults and 101.00B2 for children. Likewise, to meet listings 12.05 and 112.05, you must have mental retardation that satisfies the criteria in the introductory paragraph of those listings (the so-called capsule definition) in addition to the criteria in one of the paragraphs that follows the capsule definition; that is, listing 12.05A, B, C, or D for adults or 112.05A, B, C, D, or E for children. We explain this requirement for meeting listings 12.05 and 112.05 in the fourth paragraph of section 12.00A for adults and the eighth paragraph of section 112.00A for children.

Final §§ 404.1525(c)(3) and 416.925(c)(3) correspond to the next-to-last sentence of prior §§ 404.1525(c) and 416.925(c). However, we are expanding the information from the prior rules and clarifying it to define what we mean when we say that your impairment ''meets'' the requirements of a listing. We are deleting the explanation in the next-to-last sentence of the prior rules that the required level of severity in a listing is shown by ''one or more sets of medical findings'' and deleting the last sentence, which said that the medical findings ''consist of symptoms, signs, and laboratory findings.'' These descriptions of our listings were not accurate. We have always had some listings that also include functional criteria. Further, we have a number of listings that do not include symptoms, signs, and laboratory findings in their criteria. We are not replacing the prior sentences because we believe that the final rules are clear enough without a detailed description of all the possible kinds of criteria a given listing might contain. Instead, we simply provide that your impairment(s) meets the requirements of a listing when it satisfies all of the criteria of that listing, including any relevant criteria in the introduction to the body system, and meets the duration requirement.

Final §§ 404.1525(c)(4) and 416.925(c)(4) correspond to the last two sentences of prior §§ 404.1525(a) and 416.925(a). In the prior rules, these sentences explained that

> [m]ost of the listed impairments are permanent or expected to result in death, or a specific statement of duration is made. For all others, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months.

We are moving this language to the section of the final rules in which we

explain how we decide whether your impairment(s) meets a listing because it is most relevant to that finding. We are also making revisions to this language to better explain what we meant by the statement ''or a specific statement of duration is made'' in our prior rules. We meant by this statement that in some listings we state that we will find that your impairment(s) will meet the listing for a specific period of time. For example, in listings 13.06A and 113.06A, acute leukemia, we state that we will find that your impairment is disabling until at least 24 months from the date of diagnosis or relapse or at least 12 months from the date of the bone marrow or stem cell transplantation, whichever is later. Thereafter, we will evaluate any residual impairment under the criteria for the affected body systems.

Final §§ 404.1525(c)(5) and 416.925(c)(5) are new. They explain that when your impairment(s) does not meet a listing, it can ''medically equal'' the criteria of a listing, and provide a cross-reference to §§ 404.1526 and 416.926, our rules on medical equivalence. They also explain that when your impairment(s) does not meet or medically equal a listing we may find you disabled or still disabled at a later step in the sequential evaluation process. We do not specify the step in the process at which we may find you disabled or still disabled because there are different sequential evaluation processes for adults and children who file initial claims and for continuing disability reviews of adults and children.

We are removing prior §§ 404.1525(e) and 416.925(e) because we have more recent rules. Our policy on how we consider drug addiction and alcoholism is in §§ 404.1535 and 416.935, which we published in 1995. See 60 FR 8140, at 8147 (February 10, 1995).

Because of this deletion, we are redesignating §§ 404.1525(f) and 416.925(f) as §§ 404.1525(e) and 416.925(e). We are also simplifying these sections and making our regulations on the evaluation of symptoms more consistent by exchanging the provisions in prior §§ 404.1525(f) and 416.925(f) (final §§ 404.1525(e) and 416.925(e)) with the provisions of prior §§ 404.1529(d)(2) and 416.929(d)(2). In both prior and current §§ 404.1529(d) and 416.929(d), we explain how we consider your symptoms (such as pain) at each step of the sequential evaluation process. For example, in paragraph (d)(1) we explain how we consider your symptoms when we determine if your impairment(s) is ''severe,'' and in paragraph (d)(3) we explain how we consider your symptoms when we determine if your impairment(s) medically equals a listing. However, in prior paragraph (d)(2), instead of explaining how we consider your symptoms when we determine if your impairment meets a listing, we provided only a cross-reference to §§ 404.1525(f) and 416.925(f), where we explained our policy on symptoms and meeting listings.

For consistency, we are now moving the explanation of our policy on symptoms and meeting listings from prior §§ 404.1525(f) and 416.925(f) to §§ 404.1529(d)(2) and 416.929(d)(2) so that it is together with our explanations of how we consider symptoms at other steps in the sequential evaluation process. In final §§ 404.1525(e) and 416.925(e), we are providing a cross-reference to final §§ 404.1529(d)(2) and 416.929(d)(2) to ensure that our adjudicators refer to the provisions that we moved from prior §§ 404.1525(f) and 416.925(f) to final §§ 404.1529(d)(2) and 416.929(d)(2). As we have already noted, we are adding similar new §§ 404.1526(b)(4) and 416.926(b)(4) to provide cross-references to §§ 404.1529(d)(3) and 416.929(d)(3) to refer to our rules for considering symptoms when making medical equivalence determinations.

Sections 404.1528 and 416.928 Symptoms, Signs, and Laboratory Findings

We are deleting the opening statement of these sections, which said that ''[m]edical findings consist of symptoms, signs, and laboratory findings.'' We believe that the statement is unnecessary and that deleting it will help to remove any confusion about the evidence we consider wherever we use ''medical findings'' in our rules.

Sections 404.1529 and 416.929 How We Evaluate Symptoms, Including Pain

As we have already explained, we are replacing §§ 404.1529(d)(2) and 416.929(d)(2) with the text of prior §§ 404.1525(f) and 416.925(f). Except for minor editorial revisions, the language is unchanged.

We are adding the word ''medically'' to the heading of final §§ 404.1529(d)(3) and 416.929(d)(3) so that they read, ''Decision whether the Listing of Impairments is medically equaled.'' We are revising the third sentence in those sections, for conformity with the changes in final §§ 404.1526 and 416.926, to indicate that we will base a finding of medical equivalence on all relevant evidence in the case record about the impairment(s) and its effect on the individual.

We are making a number of minor editorial changes throughout final §§ 404.1529 and 416.929 to update them to match our current rules. For example, throughout these sections we are changing references to ''your treating or examining physician or psychologist'' to ''your treating or nontreating source.'' This change updates the rules to match the terms we use in §§ 404.1502 and 416.902 and our other rules that refer to medical sources; it does not change the meaning of the sentence. We are also correcting a cross-reference in the second sentence of §§ 404.1529(a) and 416.929(a) to reflect our current rules.

Public Comments

In the Notice of Proposed Rulemaking (NPRM) we published on June 17, 2005 (70 FR 35188), we provided the public with a 60-day period in which to comment. The period ended on August 16, 2005.

We received comments from four public commenters. One commenter sent in comments supporting the proposed changes; because it was entirely supportive, that letter did not require summary or response. We carefully considered the three remaining comment letters. Because some of the comments in these letters were long, we have condensed, summarized, and paraphrased them. We have tried, however, to summarize the commenters' views accurately and to respond to all of the significant issues raised by the commenters that were within the scope of the proposed rules. We provide our reasons for adopting or not adopting the comments in our responses below.

Comment: One commenter did not agree with our proposal to remove language from the last two sentences of prior §§ 404.1525(c) and 416.925(c). We explained in the NPRM that we proposed to delete the explanation in the next-to-last sentence of the prior rules that the required level of severity in a listing is shown by ''one or more sets of medical findings'' and to delete the last sentence, which said that the medical findings ''consist of symptoms, signs, and laboratory findings,'' because these descriptions of our listings were not accurate. The commenter disagreed, saying that ''[a]ll listings do require, in some combination, symptoms, signs and/or laboratory findings.'' The commenter further stated that the proposed rules seemed to ''over-estimate the importance of 'function[.]' '' The commenter said that any functional restriction(s) described in the listings must still result from the impairment, and that the presence of the impairment

must still be established by medical findings.

Response: We did not make any changes in the final rules as a result of this comment. Like these final rules, the proposed rules only provided a clearer explanation of the criteria various listings may contain and how we use listings. The rules indicate that ''[w]ithin each listing, we specify the objective medical and other findings needed to satisfy the criteria of that listing.'' See proposed and final §§ 404.1525(c)(3) and 416.925(c)(3). Therefore, the rules do continue to require consideration of clinical signs or laboratory findings, or both, under every listing, in addition to the symptoms and functional limitations that result from the medically determinable impairment when those factors are criteria in a listing.

Likewise, we explain that in the introductory text of listings ''we may also include specific criteria for establishing a diagnosis'' or for ''confirming the existence of an impairment.'' We also state that ''[e]ven if we do not include specific criteria for establishing a diagnosis or confirming the existence of your impairment, you must still show that you have a severe medically determinable impairment(s), as defined in [§§ 404.1508, 404.1520(c), 416.908, and 416.920(c)].'' See proposed and final §§ 404.1525(c)(2) and 416.925(c)(2). Sections 404.1508 and 416.908 of our regulations provide that an individual must show an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques, and that an impairment ''must be established by medical evidence consisting of signs, symptoms, and laboratory findings.''

Comment: The same commenter also did not support our proposal to delete the word ''medical'' from the phrase ''medical opinion'' in the last sentence of prior §§ 404.1526(b) and 416.926(b) (proposed and final §§ 404.1526(c) and 416.926(c)). The commenter said that opinions from medical or psychological consultants designated by the Commissioner ''would obviously be *medical* opinions.'' (Emphasis in original.)

Response: We did not adopt the comment because it is not correct under our regulatory definition of the term ''medical opinion.'' As we explained in the preamble to the NPRM (70 FR at 35190), ''[u]nder §§ 404.1527(a) and 416.927(a) of our regulations, the term 'medical opinion' has a specific meaning that does not include opinions about medical equivalence.'' Sections 404.1527(a)(2) and 416.927(a)(2) of our regulations define ''medical opinions'' as ''statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.'' The term ''medical opinion'' is different from the term ''medical source opinions on issues reserved to the Commissioner,'' which we define in §§ 404.1527(e) and 416.927(e) of our regulations. In those sections, we explain that opinions on some issues are not ''medical opinions,'' and we follow with examples of such opinions. In §§ 404.1527(e)(2) and 416.927(e)(2), we explain that opinions from medical sources about whether an impairment(s) meets or medically equals the requirements of a listing are ''opinions on issues reserved to the Commissioner.''

Comment: The same commenter also recommended editorial changes. The commenter recommended that we add the word ''medical'' before the words ''history'' and ''signs'' in proposed §§ 404.1529(c)(1) and (c)(4) and 416.929(c)(1) and (c)(4). The commenter also recommended that instead of using the term ''nontreating source'' throughout §§ 404.1529 and 416.929 we use the phrase ''others who have examined but not treated you.'' Finally, the commenter suggested that we add a sentence to indicate that we will consider information from the individual and from others who can provide information about the individual's medical condition.

Response: We did not adopt the comments. The reason we proposed to delete the word ''medical'' before the words ''history'' and ''sign'' in §§ 404.1529(c)(1) and (c)(4) and 416.929(c)(1) and (c)(4) is that it did not add anything meaningful to the prior regulations and could have been misinterpreted. Although we do not define the phrase ''medical history'' in our regulations, we do define the term ''complete medical history'' in §§ 404.1512(d) and 416.912(d). In those rules, we define the term as meaning ''records of your medical source(s) covering at least the 12 months preceding the month in which you file your application'' or preceding other dates in certain special situations we describe in the rules. Since we do not intend to restrict the meaning of the word ''history'' only to records from medical sources, we believe that it is important to delete the word in §§ 404.1529(c) and 416.929(c) to avoid any confusion with the term ''complete medical history.''

The reason we proposed to delete the word ''medical'' from before the word ''signs'' is that it was redundant. We define the term ''signs'' in §§ 404.1528(b) and 416.928(b) of our regulations as ''anatomical, physiological, or psychological abnormalities which can be observed, apart from your statements (symptoms)'' and explain that ''signs'' must be shown by ''medically acceptable clinical diagnostic techniques.'' Therefore, under our definition ''signs'' are always ''medical.''

There are two reasons that we did not adopt the recommendation to replace our proposed references to the term ''nontreating source'' with the phrase ''others who have examined but not treated you.'' First, the sentence proposed by the commenter was not an accurate paraphrase of our definition of ''nontreating source'' in §§ 404.1502 and 416.902 of our regulations. Under our regulations, a ''nontreating source'' may have provided treatment to the individual. Our regulations specify that a nontreating source is an acceptable medical source who ''does not have, or did not have, an *ongoing* treatment relationship'' with the individual. (Emphasis supplied.) This does not necessarily mean that the source provided no treatment; for example, an acceptable medical source who treats an individual one time in an emergency room is a ''nontreating source'' under our rules even though the source has provided some treatment. Second, and as we explained in the preamble to the NPRM (70 FR at 35193), we proposed to use the phrase ''nontreating source'' throughout §§ 404.1529 and 416.929 so that it would match our use of the term in other disability rules. If we replaced it with another phrase, it would not be consistent with those other rules.

Finally, we did not add the sentence suggested by the commenter that would provide that we consider evidence from the individual and others. The commenter did not indicate where the additional sentence should go, but in the context of the commenter's letter it appears that the commenter was suggesting that we add it to §§ 404.1529 and 416.929, our regulations that explain how we consider symptoms, such as pain. We did not adopt the comment because we already explain throughout those regulations that we consider all evidence relevant to our consideration of a person's symptoms, which can include evidence from the individual and from others who can

provide information about the individual's condition.

Comment: Another commenter indicated concerns about our policy of medical equivalence. The commenter believed that we should not review unlisted impairments under our listings because approvals ''necessarily end up based on ailments the claimant does not have and therefore cannot demonstrate as still existing upon review.'' The commenter believed that the policy of medical equivalence does not ''contribute to [an] accurate, money saving and streamlined approval process.''

The commenter was also concerned that it is more difficult for people with unlisted impairments and combinations of impairments to be approved. The commenter suggested that we update our listings to include new illnesses that are currently being approved under the present impairment listings and provide a listing for people who have a combination of impairments.

The commenter also said that it is difficult for beneficiaries to determine which doctor visits to put down on our forms when we do a continuing disability review if they do not know which impairments we considered when we found them disabled. The commenter believed that on review it would be necessary to change our records regarding an individual's impairments and that there is a chance of losing benefits because of this. Finally, the commenter made a number of comments that were relevant to another NPRM, ''Administrative Review Process for Adjudicating Initial Disability Claims,'' 70 FR 43589 (July 25, 2005).

Response: These final rules only clarify our longstanding policies for determining medical equivalence to listings. As long as the listings do not include every disabling impairment or combination of impairments that a person might have, we will still need the policy of medical equivalence to ensure that we allow individuals who should be allowed as early in our process as possible. It is often easier, faster, and less costly to find individuals disabled based on medical equivalence than to proceed to consider disability based on assessment of their residual functional capacity and their age, education, and previous work experience.

Under our policy of medical equivalence we do find individuals to be disabled based on the impairments they have even if the impairment is unlisted or there is a combination of impairments. We compare an individual's impairment or combination of impairments with a closely analogous listing for purposes of establishing the severity of the impairment(s). For example, we may find that an individual's migraine headaches (an unlisted impairment) are medically equivalent in severity to listing 11.03, a seizure disorder listing that is the most closely analogous listing we have for comparison. When we do, we find that the individual is disabled from migraine headaches that are equally as severe as the seizures described in listing 11.03; we code the individual's impairment in our computer system as migraine headaches, not seizures, and we show in the individual's case record that we found disability based on migraine headaches. Even when we do not have a specific code for an individual's particular medical impairment, we still show the medical impairment(s) we considered—not the impairment in the listing we used for comparison—in the individual's case record. Therefore, beneficiaries should not be concerned about there being a need to change our records to reflect a ''true diagnosis'' in order to avoid losing benefits. Also, we do not find individuals disabled based only on their diagnoses; rather, we consider the severity of their impairments.

Under our regulations for considering whether a beneficiary continues to be disabled, we must review the individual's case record and consider all of the impairments the individual had at the time we last found disability, including those that were not the basis for our last finding of disability. If necessary, we also consider new impairments the individual has developed since the last time we found him or her disabled. See §§ 404.1594, 416.994, and 416.994a of our regulations. Under these regulations, we generally must show that there has been medical improvement in the individual's original medical impairment(s). If there is, we must also consider all of the individual's current impairments before we can determine that the individual is no longer disabled. Therefore, when we review the continuing disability of beneficiaries, we ask them to provide us with information about all of their medical conditions since the last time we found them disabled and the names of all of the doctors and other treatment sources they have. Individuals should not choose which of their doctor visits to tell us about, but should report all of their medical history to us.

As we revise the listings, we are trying to make them more inclusive. For example, we revised the musculoskeletal listings in 2001 to place less emphasis on diagnosis and more on functional outcomes than we had in the past. Instead of listing specific diagnoses, we generally list categories of impairments; for example, ''major dysfunction of a joint(s)'' for any medical reason (see listings 1.02 and 101.02). More recently, we published revisions to the skin listings that also use categories of skin disorders instead of specific diagnoses (see sections 7.00 and 107.00 of our listings). By revising the listings in this way, we allow more people to show that their impairments are included in the listings. We also believe that more people, especially people with combinations of impairments, can show that their impairments medically equal listings when listings include these kinds of criteria. Again, our emphasis is less on the specific medical conditions the individuals have and more on the specific effects the impairments have on their ability to work (or in the case of a child, to function compared to other children the same age who do not have impairments).

The comments that were relevant to the other NPRM cited above were outside the scope of this rulemaking. They are included with the public comments for that NPRM and we will address them when we issue final rules in connection with that NPRM.

Comment: The last commenter's letter first noted that

> * * * at least some of the listings can be broken down into (a) cause[s] and (b) effects. That is to say, someone will 'meet' the listings if they have the listed cause(s) *and* the listed effects.

The commenter asked whether the causes and effects are both ''findings'' and if not, why not. The commenter further said that ''[t]he proposed regulations appear[ed] to emphasize cause over effects,'' that this would ''require assessments which are both subjective [and] arbitrary,'' and that ''[a]s long as a 'severe' *cause(s)* [is] present, it is the *effects* of the *cause(s)* that render someone disabled.'' (Emphasis in original.) The commenter provided an example of one individual who was blinded by a cannon firing buckshot and who sustained significant ''collateral damage'' and a second individual who was blinded by a BB gun. He concluded: ''Perhaps we should pay most of our attention to the effects. * * * If they are both blind, then they are both blind.''

On the other hand, the commenter also suggested that our ''regulations should re-direct [our] focus to both (a) 'severe' cause(s), *and* (b) the listed 'severe' effects.'' (Emphasis in original.)

The commenter did not elaborate on this observation.

Response: We did not make any changes in the final rules in response to this comment, in part because the comment was not clear to us. We believe the commenter was referring primarily to the language in proposed (now final) §§ 404.1526(b)(2) and (b)(3) and 416.926(b)(2) and (b)(3) that explained that we compare the ''findings'' related to an individual's impairment(s) to the findings of a listing. (The word ''findings'' also appears in §§ 404.1526(b)(1) and 416.926(b)(1), but in that context the claimant has the listed impairment, and it would not appear to be relevant to this comment.) It appears that the commenter believed that there are listings that consider the cause of the individual's medically determinable impairment(s), and that in some cases the cause of an individual's impairment would not be as severe as the cause of the impairment we include in the listing we are using for comparison; using the commenter's example, being shot with a cannon as compared to being shot with a BB gun, even though both result in blindness.

The commenter's observations and example were erroneous for two reasons. First, the listings do not include findings about how an individual specifically acquires an impairment. The listings use symptoms, signs, and laboratory findings to describe medical conditions (that is, what we call ''impairments'') and do not specify that individuals must demonstrate how they acquired their impairments. Even in listings such as listings 12.05 and 112.05, which specify that the impairment must have been present since before age 22, or listings 12.02 and 112.02, which specify that there must be an organic basis for the required dysfunction of the brain, there is no requirement to specify particular causes of particular severity for these impairments. The findings in our listings establish only that the impairments exist and how serious they are.

Second, an impairment(s) that medically equals a listing cannot by definition be objectively less serious than a listed impairment. The nature of the impairment cannot be separated from the severity criteria; for example, a dysthymic disorder (an unlisted impairment) that medically equals listing 12.04A1, major depressive disorder, because it results in ''marked'' limitations of functioning in two of the areas described in paragraph 12.04B is by definition as medically severe as a major depressive disorder. The test of medical equivalence is whether the totality of the individual's findings are equivalent in severity to the totality of the findings in the listing we use for comparison.

It should also be noted that most of our current listings are not diagnosis-specific, but more categorical. For example, as we have already noted in response to the first commenter's letter, most of our musculoskeletal listings describe categories of musculoskeletal problems regardless of their cause, instead of specific diagnoses; for example, major dysfunction of major peripheral joints or disorders of the spine. The same can be said for many other listings in other body systems, including our listings for blindness. Therefore, the question whether the ''cause'' of an individual's impairment is less serious than the ''cause'' of a listed impairment could not arise in such listings since the emphasis is on the comparison of the ''effects.''

The proposed (now final) rules explaining how an individual's impairment(s) medically equals a listing for the most part repeated language that has been in our regulations and other instructions for many years. They did not emphasize ''cause'' over ''effects'' but merely indicated that an individual must have findings of equivalent severity to findings in a given listing. If anything, our deletion of references to ''medical'' evidence in the proposed rules and these final rules emphasized the predominant importance of the ''effects'' of impairments over their causes.

Regulatory Procedures

Executive Order 12866

We have consulted with the Office of Management and Budget (OMB) and determined that these rules meet the criteria for a significant regulatory action under Executive Order 12866, as amended by Executive Order 13258. Thus, they were reviewed by OMB.

Regulatory Flexibility Act

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

Paperwork Reduction Act

The Paperwork Reduction Act (PRA) of 1995 says that no persons are required to respond to a collection of information unless it displays a valid OMB control number. In accordance with the PRA, SSA is providing notice that the Office of Management and Budget has approved the information collection requirements contained in sections 404.918(d) and 416.1418(d) of these final rules. The OMB Control Number for this collection is 0960–0709, expiring October 31, 2008.

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

List of Subjects

20 CFR Part 404

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

20 CFR Part 416

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

Dated: December 12, 2005.

Jo Anne B. Barnhart,

Commissioner of Social Security.

For the reasons set forth in the preamble, subparts J and P of part 404 and subparts I and N of part 416 of chapter III of title 20 of the Code of Federal Regulations are amended as set forth below:

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

Subpart J—[Amended]

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

Authority: Secs. 201(j), 204(f), 205(a), (b), (d)–(h), and (j), 221, 223(i), 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 401(j), 404(f), 405(a), (b), (d)–(h), and (j), 421, 423(i), 425, and 902(a)(5)); sec. 5, Pub. L. 97–455, 96 Stat. 2500 (42 U.S.C. 405 note); secs. 5, 6(c)–(e), and 15, Pub. L. 98–460, 98 Stat. 1802 (42 U.S.C. 421 note).

■ 2. Section 404.914 is amended by revising the first sentence of paragraph (c)(1) to read as follows:

§ 404.914 Disability hearing—general.

* * * * *

(c) *Time and place*—(1) *General.* Either the State agency or the Associate Commissioner for Disability Determinations or his or her delegate, as appropriate, will set the time and place of your disability hearing. * * *

* * * * *

■ 3. Section 404.915 is amended by revising the second sentence of paragraph (a) and paragraph (c) introductory text to read as follows:

§ 404.915 Disability Hearing—disability hearing officers.

(a) *General.* * * * The disability hearing officer will be an experienced disability examiner, regardless of whether he or she is appointed by a State agency or by the Associate Commissioner for Disability Determinations or his or her delegate, as described in paragraphs (b) and (c) of this section.

* * * * *

(c) *Federal hearing officers.* The disability hearing officer who conducts your disability hearing will be appointed by the Associate Commissioner for Disability Determinations or his or her delegate if:

* * * * *

■ 4. Section 404.917 is amended by revising paragraph (d) to read as follows:

§ 404.917 Disability hearing—disability hearing officer's reconsidered determination.

* * * * *

(d) *Effect.* The disability hearing officer's reconsidered determination, or, if it is changed under § 404.918, the reconsidered determination that is issued by the Associate Commissioner for Disability Determinations or his or her delegate, is binding in accordance with § 404.921, subject to the exceptions specified in that section.

■ 5. Section 404.918 is revised to read as follows:

§ 404.918 Disability hearing—review of the disability hearing officer's reconsidered determination before it is issued.

(a) *General.* The Associate Commissioner for Disability Determinations or his or her delegate may select a sample of disability hearing officers' reconsidered determinations, before they are issued, and review any such case to determine its correctness on any grounds he or she deems appropriate. The Associate Commissioner or his or her delegate shall review any case within the sample if:

(1) There appears to be an abuse of discretion by the hearing officer;

(2) There is an error of law; or

(3) The action, findings or conclusions of the disability hearing officer are not supported by substantial evidence.

Note to paragraph (a): If the review indicates that the reconsidered determination prepared by the disability hearing officer is correct, it will be dated and issued immediately upon completion of the review. If the reconsidered determination prepared by the disability hearing officer is found by the Associate Commissioner or his or her delegate to be deficient, it will be changed as described in paragraph (b) of this section.

(b) *Methods of correcting deficiencies in the disability hearing officer's reconsidered determination.* If the reconsidered determination prepared by the disability hearing officer is found by the Associate Commissioner for Disability Determinations or his or her delegate to be deficient, the Associate Commissioner or his or her delegate will take appropriate action to assure that the deficiency is corrected before a reconsidered determination is issued. The action taken by the Associate Commissioner or his or her delegate will take one of two forms:

(1) The Associate Commissioner or his or her delegate may return the case file either to the component responsible for preparing the case for hearing or to the disability hearing officer, for appropriate further action; or

(2) The Associate Commissioner or his or her delegate may issue a written reconsidered determination which corrects the deficiency.

(c) *Further action on your case if it is sent back by the Associate Commissioner for Disability Determinations or his or her delegate either to the component that prepared your case for hearing or to the disability hearing officer.* If the Associate Commissioner for Disability Determinations or his or her delegate sends your case back either to the component responsible for preparing the case for hearing or to the disability hearing officer for appropriate further action, as provided in paragraph (b)(1) of this section, any additional proceedings in your case will be governed by the disability hearing procedures described in § 404.916(f) or if your case is returned to the disability hearing officer and an unfavorable determination is indicated, a supplementary hearing may be scheduled for you before a reconsidered determination is reached in your case.

(d) *Opportunity to comment before the Associate Commissioner for Disability Determinations or his or her delegate issues a reconsidered determination that is unfavorable to you.* If the Associate Commissioner for Disability Determinations or his or her delegate proposes to issue a reconsidered determination as described in paragraph (b)(2) of this section, and that reconsidered determination is unfavorable to you, he or she will send you a copy of the proposed reconsidered determination with an explanation of the reasons for it, and will give you an opportunity to submit written comments before it is issued. At your request, you will also be given an opportunity to inspect the pertinent materials in your case file, including the reconsidered determination prepared by the disability hearing officer, before submitting your comments. You will be given 10 days from the date you receive the Associate Commissioner's notice of proposed action to submit your written comments, unless additional time is necessary to provide access to the pertinent file materials or there is good cause for providing more time, as illustrated by the examples in § 404.911(b). The Associate Commissioner or his or her delegate will consider your comments before taking any further action on your case.

Subpart P—[Amended]

■ 6. 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 902(a) (5)); sec. 211(b), Pub. L. 104–193, 110 Stat. 2105, 2189.

■ 7. Section 404.1525 is revised to read as follows:

§ 404.1525 Listing of Impairments in appendix 1.

(a) *What is the purpose of the Listing of Impairments?* The Listing of Impairments (the listings) is in appendix 1 of this subpart. It describes for each of the major body systems impairments that we consider to be severe enough to prevent an individual from doing any gainful activity, regardless of his or her age, education, or work experience.

(b) *How is appendix 1 organized?* There are two parts in appendix 1:

(1) *Part A* contains criteria that apply to individuals age 18 and over. We may also use part A for individuals who are under age 18 if the disease processes have a similar effect on adults and children.

(2) *Part B* contains criteria that apply only to individuals who are under age 18; we never use the listings in part B to evaluate individuals who are age 18 or older. In evaluating disability for a person under age 18, we use part B first. If the criteria in part B do not apply, we may use the criteria in part A when those criteria give appropriate consideration to the effects of the

impairment(s) in children. To the extent possible, we number the provisions in part B to maintain a relationship with their counterparts in part A.

(c) *How do we use the listings?* (1) Each body system section in parts A and B of appendix 1 is in two parts: an introduction, followed by the specific listings.

(2) The introduction to each body system contains information relevant to the use of the listings in that body system; for example, examples of common impairments in the body system and definitions used in the listings for that body system. We may also include specific criteria for establishing a diagnosis, confirming the existence of an impairment, or establishing that your impairment(s) satisfies the criteria of a particular listing in the body system. Even if we do not include specific criteria for establishing a diagnosis or confirming the existence of your impairment, you must still show that you have a severe medically determinable impairment(s), as defined in §§ 404.1508 and 404.1520(c).

(3) The specific listings follow the introduction in each body system, after the heading, *Category of Impairments*. Within each listing, we specify the objective medical and other findings needed to satisfy the criteria of that listing. We will find that your impairment(s) meets the requirements of a listing when it satisfies all of the criteria of that listing, including any relevant criteria in the introduction, and meets the duration requirement (see § 404.1509).

(4) Most of the listed impairments are permanent or expected to result in death. For some listings, we state a specific period of time for which your impairment(s) will meet the listing. For all others, the evidence must show that your impairment(s) has lasted or can be expected to last for a continuous period of at least 12 months.

(5) If your impairment(s) does not meet the criteria of a listing, it can medically equal the criteria of a listing. We explain our rules for medical equivalence in § 404.1526. We use the listings only to find that you are disabled or still disabled. If your impairment(s) does not meet or medically equal the criteria of a listing, we may find that you are disabled or still disabled at a later step in the sequential evaluation process.

(d) *Can your impairment(s) meet a listing based only on a diagnosis?* No. Your impairment(s) cannot meet the criteria of a listing based only on a diagnosis. To meet the requirements of a listing, you must have a medically determinable impairment(s) that satisfies all of the criteria in the listing.

(e) *How do we consider your symptoms when we determine whether your impairment(s) meets a listing?* Some listed impairments include symptoms, such as pain, as criteria. Section 404.1529(d)(2) explains how we consider your symptoms when your symptoms are included as criteria in a listing.

■ 8. Section 404.1526 is amended by revising paragraphs (a) and (b), revising the heading of paragraph (c) and redesignating paragraph (c) as paragraph (d), and adding new paragraphs (c) and (e), to read as follows:

§ 404.1526 Medical equivalence.

(a) *What is medical equivalence?* Your impairment(s) is medically equivalent to a listed impairment in appendix 1 if it is at least equal in severity and duration to the criteria of any listed impairment.

(b) *How do we determine medical equivalence?* We can find medical equivalence in three ways.

(1)(i) If you have an impairment that is described in appendix 1, but —

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

(B) You exhibit all of the findings, but one or more of the findings is not as severe as specified in the particular listing,

(ii) We will find that your impairment is medically equivalent to that listing if you have other findings related to your impairment that are at least of equal medical significance to the required criteria.

(2) If you have an impairment(s) that is not described in appendix 1, we will compare your findings with those for closely analogous listed impairments. If the findings related to your impairment(s) are at least of equal medical significance to those of a listed impairment, we will find that your impairment(s) is medically equivalent to the analogous listing.

(3) If you have a combination of impairments, no one of which meets a listing (see § 404.1525(c)(3)), we will compare your findings with those for closely analogous listed impairments. If the findings related to your impairments are at least of equal medical significance to those of a listed impairment, we will find that your combination of impairments is medically equivalent to that listing.

(4) Section 404.1529(d)(3) explains how we consider your symptoms, such as pain, when we make findings about medical equivalence.

(c) *What evidence do we consider when we determine if your impairment(s) medically equals a listing?* When we determine if your impairment medically equals a listing, we consider all evidence in your case record about your impairment(s) and its effects on you that is relevant to this finding. We do not consider your vocational factors of age, education, and work experience (see, for example, § 404.1560(c)(1)). We also consider the opinion given by one or more medical or psychological consultants designated by the Commissioner. (See § 404.1616.)

(d) *Who is a designated medical or psychological consultant?* * * *

(e) *Who is responsible for determining medical equivalence?* In cases where the State agency or other designee of the Commissioner makes the initial or reconsideration disability determination, a State agency medical or psychological consultant or other designee of the Commissioner (see § 404.1616) has the overall responsibility for determining medical equivalence. For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining medical equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsideration determination is changed under § 404.918, with the Associate Commissioner for Disability Determinations or his or her delegate. For cases at the Administrative Law Judge or Appeals Council level, the responsibility for deciding medical equivalence rests with the Administrative Law Judge or Appeals Council.

§ 404.1528 [Amended]

■ 9. Section 404.1528 is amended by removing the introductory text before paragraph (a).

■ 10. Section 404.1529 is amended by revising the third, fourth, and fifth sentences in paragraph (a), the fifth sentence in paragraph (b), the second sentence in paragraph (c)(1), the second, third, and fourth sentences in paragraph (c)(3) introductory text, the third sentence in paragraph (c)(4), paragraph (d)(2), and the heading and the third sentence in paragraph (d)(3), to read as follows:

§ 404.1529 How we evaluate symptoms, including pain.

(a) *General.* * * * By other evidence, we mean the kinds of evidence described in §§ 404.1512(b)(2) through (6) and 404.1513(b)(1), (4), and (5), and (d). These include statements or reports from you, your treating or nontreating source, and others about your medical history, diagnosis, prescribed treatment,

daily activities, efforts to work, and any other evidence showing how your impairment(s) and any related symptoms affect your ability to work. We will consider all of your statements about your symptoms, such as pain, and any description you, your treating source or nontreating source, or other persons may provide about how the symptoms affect your activities of daily living and your ability to work. * * *

(b) *Need for medically determinable impairment that could reasonably be expected to produce your symptoms, such as pain.* * * * At the administrative law judge hearing or Appeals Council level, the administrative law judge or the Appeals Council may ask for and consider the opinion of a medical expert concerning whether your impairment(s) could reasonably be expected to produce your alleged symptoms. * * *

(c) *Evaluating the intensity and persistence of your symptoms, such as pain, and determining the extent to which your symptoms limit your capacity for work.* (1) *General.* * * * In evaluating the intensity and persistence of your symptoms, we consider all of the available evidence, including your history, the signs and laboratory findings, and statements from you, your treating or nontreating source, or other persons about how your symptoms affect you. * * *

* * * * *

(3) *Consideration of other evidence.* * * * The information that you, your treating or nontreating source, or other persons provide about your pain or other symptoms (*e.g.*, what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions which you, your treating or nontreating source, or other persons report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your treating or nontreating source, and observations by our employees and other persons. * * *

(4) *How we determine the extent to which symptoms, such as pain, affect your capacity to perform basic work activities.* * * * We will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between your statements and the rest of the evidence, including your history, the signs and laboratory findings, and statements by your treating or nontreating source or other persons about how your symptoms affect you. * * *

(d) *Consideration of symptoms in the disability determination process.*

* * * * *

(2) *Decision whether the Listing of Impairments is met.* Some listed impairments include symptoms usually associated with those impairments as criteria. Generally, when a symptom is one of the criteria in a listing, it is only necessary that the symptom be present in combination with the other criteria. It is not necessary, unless the listing specifically states otherwise, to provide information about the intensity, persistence, or limiting effects of the symptom as long as all other findings required by the specific listing are present.

(3) *Decision whether the Listing of Impairments is medically equaled.* * * * Under § 404.1526(b), we will consider medical equivalence based on all evidence in your case record about your impairment(s) and its effects on you that is relevant to this finding.

* * *

* * * * *

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

Subpart I—[Amended]

■ 11. The authority citation for subpart I of part 416 is revised to read as follows:

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

■ 12. Section 416.925 is revised to read as follows:

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

(a) *What is the purpose of the Listing of Impairments?* The Listing of Impairments (the listings) is in appendix 1 of subpart P of part 404 of this chapter. For adults, it describes for each of the major body systems impairments that we consider to be severe enough to prevent an individual from doing any gainful activity, regardless of his or her age, education, or work experience. For children, it describes impairments that cause marked and severe functional limitations.

(b) *How is appendix 1 organized?* There are two parts in appendix 1:

(1) *Part A* contains criteria that apply to individuals age 18 and over. We may also use part A for individuals who are under age 18 if the disease processes have a similar effect on adults and children.

(2)(i) *Part B* contains criteria that apply only to individuals who are under age 18; we never use the listings in part B to evaluate individuals who are age 18 or older. In evaluating disability for a person under age 18, we use part B first. If the criteria in part B do not apply, we may use the criteria in part A when those criteria give appropriate consideration to the effects of the impairment(s) in children. To the extent possible, we number the provisions in part B to maintain a relationship with their counterparts in part A.

(ii) Although the severity criteria in part B of the listings are expressed in different ways for different impairments, ''listing-level severity'' generally means the level of severity described in § 416.926a(a); that is, ''marked'' limitations in two domains of functioning or an ''extreme'' limitation in one domain. (See § 416.926a(e) for the definitions of the terms *marked* and *extreme* as they apply to children.) Therefore, in general, a child's impairment(s) is of ''listing-level severity'' if it causes marked limitations in two domains of functioning or an extreme limitation in one. However, when we decide whether your impairment(s) meets the requirements of a listing, we will decide that your impairment is of ''listing-level severity'' even if it does not result in marked limitations in two domains of functioning, or an extreme limitation in one, if the listing that we apply does not require such limitations to establish that an impairment(s) is disabling.

(c) *How do we use the listings?* (1) Each body system section in parts A and B of appendix 1 of subpart P of part 404 of this chapter is in two parts: an introduction, followed by the specific listings.

(2) The introduction to each body system contains information relevant to the use of the listings in that body system; for example, examples of common impairments in the body system and definitions used in the

listings for that body system. We may also include specific criteria for establishing a diagnosis, confirming the existence of an impairment, or establishing that your impairment(s) satisfies the criteria of a particular listing in the body system. Even if we do not include specific criteria for establishing a diagnosis or confirming the existence of your impairment, you must still show that you have a severe medically determinable impairment(s), as defined in §§ 416.908, 416.920(c), and 416.924(c).

(3) The specific listings follow the introduction in each body system, after the heading, *Category of Impairments.* Within each listing, we specify the objective medical and other findings needed to satisfy the criteria of that listing. We will find that your impairment(s) *meets* the requirements of a listing when it satisfies all of the criteria of that listing, including any relevant criteria in the introduction, and meets the duration requirement (see § 416.909).

(4) Most of the listed impairments are permanent or expected to result in death. For some listings, we state a specific period of time for which your impairment(s) will meet the listing. For all others, the evidence must show that your impairment(s) has lasted or can be expected to last for a continuous period of at least 12 months.

(5) If your impairment(s) does not meet the criteria of a listing, it can *medically equal* the criteria of a listing. We explain our rules for medical equivalence in § 416.926. We use the listings only to find that you are disabled or still disabled. If your impairment(s) does not meet or medically equal the criteria of a listing, we may find that you are disabled or still disabled at a later step in the sequential evaluation process.

(d) *Can your impairment(s) meet a listing based only on a diagnosis?* No. Your impairment(s) cannot meet the criteria of a listing based only on a diagnosis. To meet the requirements of a listing, you must have a medically determinable impairment(s) that satisfies all of the criteria of the listing.

(e) *How do we consider your symptoms when we determine whether your impairment(s) meets a listing?* Some listed impairments include symptoms, such as pain, as criteria. Section 416.929(d)(2) explains how we consider your symptoms when your symptoms are included as criteria in a listing.

■ 13. Section 416.926 is amended by revising paragraphs (a) and (b), revising the heading of paragraph (c), redesignating paragraphs (c) and (d) as paragraphs (d) and (e), revising the heading of newly redesignated paragraph (d), revising the heading and second sentence of newly redesignated paragraph (e), and adding a new paragraph (c) to read as follows:

§ 416.926 Medical equivalence for adults and children.

(a) *What is medical equivalence?* Your impairment(s) is medically equivalent to a listed impairment in appendix 1 of subpart P of part 404 of this chapter if it is at least equal in severity and duration to the criteria of any listed impairment.

(b) *How do we determine medical equivalence?* We can find medical equivalence in three ways.

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

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

(B) You exhibit all of the findings, but one or more of the findings is not as severe as specified in the particular listing,

(ii) We will find that your impairment is medically equivalent to that listing if you have other findings related to your impairment that are at least of equal medical significance to the required criteria.

(2) If you have an impairment(s) that is not described in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter, we will compare your findings with those for closely analogous listed impairments. If the findings related to your impairment(s) are at least of equal medical significance to those of a listed impairment, we will find that your impairment(s) is medically equivalent to the analogous listing.

(3) If you have a combination of impairments, no one of which meets a listing described in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter (see § 416.925(c)(3)), we will compare your findings with those for closely analogous listed impairments. If the findings related to your impairments are at least of equal medical significance to those of a listed impairment, we will find that your combination of impairments is medically equivalent to that listing.

(4) Section 416.929(d)(3) explains how we consider your symptoms, such as pain, when we make findings about medical equivalence.

(c) *What evidence do we consider when we determine if your impairment(s) medically equals a listing?* When we determine if your impairment medically equals a listing, we consider all evidence in your case record about your impairment(s) and its effects on you that is relevant to this finding. We do not consider your vocational factors of age, education, and work experience (see, for example, § 416.960(c)(1)). We also consider the opinion given by one or more medical or psychological consultants designated by the Commissioner. (See § 416.1016.)

(d) *Who is a designated medical or psychological consultant?* * * *

(e) *Who is responsible for determining medical equivalence?* * * * For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining medical equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsideration determination is changed under § 416.1418, with the Associate Commissioner for Disability Determinations or his or her delegate. * * *

§ 416.928 [Amended]

■ 14. Section 416.928 is amended by removing the introductory sentence before paragraph (a).

■ 15. Section 416.929 is amended by revising the third, fourth, and fifth sentences in paragraph (a), the fifth sentence in paragraph (b), the second sentence in paragraph (c)(1), the second, third, and fourth sentences in paragraph (c)(3) introductory text, the third sentence in paragraph (c)(4), paragraph (d)(2), and the third sentence in paragraph (d)(3), to read as follows:

§ 416.929 How we evaluate symptoms, including pain.

(a) *General.* * * * By other evidence, we mean the kinds of evidence described in §§ 416.912(b)(2) through (6) and 416.913(b)(1), (4), and (5), and (d). These include statements or reports from you, your treating or nontreating source, and others about your medical history, diagnosis, prescribed treatment, daily activities, efforts to work, and any other evidence showing how your impairment(s) and any related symptoms affect your ability to work (or, if you are a child, your functioning). We will consider all of your statements about your symptoms, such as pain, and any description you, your treating source or nontreating source, or other persons may provide about how the symptoms affect your activities of daily living and your ability to work (or, if you are a child, your functioning). * * *

(b) *Need for medically determinable impairment that could reasonably be expected to produce your symptoms, such as pain.* * * * At the administrative law judge hearing or Appeals Council level, the administrative law judge or the Appeals Council may ask for and consider the opinion of a medical expert concerning whether your impairment(s) could reasonably be expected to produce your alleged symptoms. * * *

(c) *Evaluating the intensity and persistence of your symptoms, such as pain, and determining the extent to which your symptoms limit your capacity for work or, if you are a child, your functioning.*—(1) *General.* * * * In evaluating the intensity and persistence of your symptoms, we consider all of the available evidence, including your history, the signs and laboratory findings, and statements from you, your treating or nontreating source, or other persons about how your symptoms affect you. * * *

(3) *Consideration of other evidence.* * * * The information that you, your treating or nontreating source, or other persons provide about your pain or other symptoms (*e.g.*, what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions which you, your treating or nontreating source, or other persons report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your treating or nontreating source, and observations by our employees and other persons. * * *

(4) *How we determine the extent to which symptoms, such as pain, affect your capacity to perform basic work activities, or if you are a child, your functioning.* * * * We will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between your statements and the rest of the evidence, including your history, the signs and laboratory findings, and statements by your treating or nontreating source or other persons about how your symptoms affect you. * * *

* * * * *

(d) *Consideration of symptoms in the disability determination process.*

* * * * *

(2) *Decision whether the Listing of Impairments is met.* Some listed impairments include symptoms usually associated with those impairments as criteria. Generally, when a symptom is one of the criteria in a listing, it is only necessary that the symptom be present in combination with the other criteria. It is not necessary, unless the listing specifically states otherwise, to provide information about the intensity, persistence, or limiting effects of the symptom as long as all other findings required by the specific listing are present.

(3) *Decision whether the Listing of Impairments is medically equaled.* * * * Under § 416.926(b), we will consider medical equivalence based on all evidence in your case record about your impairment(s) and its effects on you that is relevant to this finding. * * *

* * * * *

Subpart N—[Amended]

■ 16. The authority citation for subpart N of part 416 continues to read as follows:

Authority: Secs. 702(a)(5), 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1383, and 1383b).

■ 17. Section 416.1414 is amended by revising the first sentence of paragraph (c)(1) to read as follows:

§ 416.1414 Disability hearing—general.

* * * * *

(c) *Time and place*—(1) *General.* Either the State agency or the Associate Commissioner for Disability Determinations or his or her delegate, as appropriate, will set the time and place of your disability hearing. * * *

* * * * *

■ 18. Section 416.1415 is amended by revising the second sentence of paragraph (a) and paragraph (c) introductory text to read as follows:

§ 416.1415 Disability Hearing—disability hearing officers.

(a) *General.* * * * The disability hearing officer will be an experienced disability examiner, regardless of whether he or she is appointed by a State agency or by the Associate Commissioner for Disability Determinations or his or her delegate, as described in paragraphs (b) and (c) of this section.

* * * * *

(c) *Federal hearing officers.* The disability hearing officer who conducts your disability hearing will be appointed by the Associate Commissioner for Disability Determinations or his or her delegate if:

* * * * *

■ 19. Section 416.1417 is amended by revising paragraph (d) to read as follows:

§ 416.1417 Disability hearing—disability hearing officer's reconsidered determination.

* * * * *

(d) *Effect.* The disability hearing officer's reconsidered determination, or, if it is changed under § 416.1418, the reconsidered determination that is issued by the Associate Commissioner for Disability Determinations or his or her delegate, is binding in accordance with § 416.1421, subject to the exceptions specified in that section.

■ 20. Section 416.1418 is revised to read as follows:

§ 416.1418 Disability hearing—review of the disability hearing officer's reconsidered determination before it is issued.

(a) *General.* The Associate Commissioner for Disability Determinations or his or her delegate may select a sample of disability hearing officers' reconsidered determinations, before they are issued, and review any such case to determine its correctness on any grounds he or she deems appropriate. The Associate Commissioner or his or her delegate shall review any case within the sample if:

(1) There appears to be an abuse of discretion by the hearing officer;

(2) There is an error of law; or

(3) The action, findings or conclusions of the disability hearing officer are not supported by substantial evidence.

Note to paragraph (a): If the review indicates that the reconsidered determination prepared by the disability hearing officer is correct, it will be dated and issued immediately upon completion of the review. If the reconsidered determination prepared by the disability hearing officer is found by the Associate Commissioner or his or her delegate to be deficient, it will be changed as described in paragraph (b) of this section.

(b) *Methods of correcting deficiencies in the disability hearing officer's reconsidered determination.* If the reconsidered determination prepared by the disability hearing officer is found by

the Associate Commissioner for Disability Determinations or his or her delegate to be deficient, the Associate Commissioner or his or her delegate will take appropriate action to assure that the deficiency is corrected before a reconsidered determination is issued. The action taken by the Associate Commissioner or his or her delegate will take one of two forms:

(1) The Associate Commissioner or his or her delegate may return the case file either to the component responsible for preparing the case for hearing or to the disability hearing officer, for appropriate further action; or

(2) The Associate Commissioner or his or her delegate may issue a written reconsidered determination which corrects the deficiency.

(c) *Further action on your case if it is sent back by the Associate Commissioner for Disability Determinations or his or her delegate either to the component that prepared your case for hearing or to the disability hearing officer.* If the Associate Commissioner for Disability Determinations or his or her delegate sends your case back either to the component responsible for preparing the case for hearing or to the disability hearing officer for appropriate further action, as provided in paragraph (b)(1) of this section, any additional proceedings in your case will be governed by the disability hearing procedures described in § 416.1416(f) or if your case is returned to the disability hearing officer and an unfavorable determination is indicated, a supplementary hearing may be scheduled for you before a reconsidered determination is reached in your case.

(d) *Opportunity to comment before the Associate Commissioner for Disability Determinations or his or her delegate issues a reconsidered determination that is unfavorable to you.* If the Associate Commissioner for Disability Determinations or his or her delegate proposes to issue a reconsidered determination as described in paragraph (b)(2) of this section, and that reconsidered determination is unfavorable to you, he or she will send you a copy of the proposed reconsidered determination with an explanation of the reasons for it, and will give you an opportunity to submit written comments before it is issued. At your request, you will also be given an opportunity to inspect the pertinent materials in your case file, including the reconsidered determination prepared by the disability hearing officer, before submitting your comments. You will be given 10 days from the date you receive the Associate Commissioner's notice of proposed action to submit your written comments, unless additional time is necessary to provide access to the pertinent file materials or there is good cause for providing more time, as illustrated by the examples in § 416.1411(b). The Associate Commissioner or his or her delegate will consider your comments before taking any further action on your case.

[FR Doc. 06–1872 Filed 2–28–06; 8:45 am]

BILLING CODE 4191–02–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 866

[Docket No. 2003P–0564]

Microbiology Devices; Reclassification of Hepatitis A Virus Serological Assays; Correction

AGENCY: Food and Drug Administration, HHS.

ACTION: Final rule; correction.

SUMMARY: The Food and Drug Administration (FDA) is correcting a final rule that appeared in the **Federal Register** of February 9, 2006 (71 FR 6677). That document reclassified hepatitis A virus (HAV) serological assays from class III (premarket approval) into class II (special controls). That document inadvertently published with an error. This document corrects the error.

DATES: This rule is effective March 13, 2006.

FOR FURTHER INFORMATION CONTACT: Sally Hojvat, Center for Devices and Radiological Health (HFZ–440), Food and Drug Administration, 9200 Corporate Blvd., Rockville, MD 20850, 240–276–0496.

SUPPLEMENTARY INFORMATION: In FR Doc. 06–1206, appearing on page 6677 in the **Federal Register** of Thursday, February 9, 2006, the following correction is made:

1. On page 6679, beginning in the first column, under section ''VI. Analysis of Impacts,'' the second paragraph is corrected to read:

The Regulatory Flexibility Act requires agencies to analyze regulatory options that would minimize any significant impact of a rule on small entities. Reclassification of HAV serological assays from class III into class II will relieve manufacturers of the cost of complying with the premarket approval requirements in section 515 of the act. Because reclassification will reduce regulatory costs with respect to these devices, the agency certifies that the final rule will not have a significant economic impact on a substantial number of small entities.

Dated: February 21, 2006.

Linda S. Kahan,

Deputy Director, Center for Devices and Radiological Health.

[FR Doc. 06–1871 Filed 2–28–06; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[CGD05–05–079]

RIN 1625–AA09

Drawbridge Operation Regulations; New Jersey Intracoastal Waterway, Manasquan River

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is temporarily changing the operating regulations that govern the operation of the Route 35 Bridge, at New Jersey Intracoastal Waterway (NJICW) mile 1.1, across Manasquan River, at Brielle, New Jersey. The bridge will be closed to navigation on three four-month closure periods from 8 a.m. November 1, 2006 until 5 p.m. March 1, 2007; from 8 a.m. on November 1, 2007 until 5 p.m. March 1, 2008; and from 8 a.m. on November 1, 2008 until 5 p.m. March 1, 2009. Extensive structural, mechanical, and electrical repairs and improvements necessitate these closures.

DATES: This temporary final rule is effective from April 17, 2006.

ADDRESSES: The 5th Coast Guard District maintains the public docket for this rulemaking. Comments and material received from the public, as well as documents indicated in this preamble as being available in the docket are part of docket CGD05–05–079 and are available for inspection or copying at Commander (obr), Fifth Coast Guard District, Federal Building, 4th Floor, 431 Crawford Street, Portsmouth, Virginia 23703–5004, between 8 a.m. and 4 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Gary Heyer, Bridge Management Specialist, Fifth Coast Guard District, at (757) 398–6629.

SUPPLEMENTARY INFORMATION:

Regulatory Information

On July 20, 2005, we published a notice of proposed rule making (NPRM)