section 5.2.3 to Procedure 1 to read as follows:

Appendix F—Quality Assurance Procedures

* * * * *

5.2 Excessive Audit Inaccuracy. If the RA, using the RATA, CGA, or RAA exceeds the criteria in section 5.2.3, the CEMS is out-of-control. If the CEMS is out-of-control, take necessary corrective action to eliminate the problem. Following corrective action, the source owner or operator must audit the CEMS with a RATA, CGA, or RAA to determine if the CEMS is operating within the specifications. A RATA must always be used following an out-of-control period resulting from a RATA. The audit following corrective action does not require analysis of EPA performance audit samples. If audit results show the CEMS to be out-of-control, the CEMS operator shall report both the audit showing the CEMS to be out-of-control and the results of the audit following corrective action showing the CEMS to be operating within specifications.

* * * * *

5.2.3 Criteria for Excessive Audit Inaccuracy. Unless specified otherwise in the applicable subpart, the criteria for excessive inaccuracy are:

(1) For the RATA, the allowable RA in the applicable PS in Appendix B.

(2) For the CGA, ±15 percent of the average audit value or ±5 ppm, whichever is greater.

(3) For the RAA, ±15 percent of the three run average or ±7.5 percent of the applicable standard, whichever is greater.

* * * * *

Appendix F—[Amended]

4. In Appendix F, by revising the eleventh entry of Figure 1 of Procedure 1 to read as follows:

CEMS span values as per the applicable regulation: ________ (e.g., SO_2 ________ ppm, NO_x ________ ppm).

[FR Doc. 91–1401 Filed 2–8–91; 8:45 am]

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federal register

Monday
February 11, 1991

Part IV

Department of the Interior

Bureau of Indian Affairs

Tribal Self-Governance Demonstration Planning Grant Program; Notice of Availability

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Office of Self-Governance; Tribal Self-Governance Demonstration Planning Grant Program

February 5, 1991.

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Announcement of availability of competitive planning grant funds for certain federally recognized Indian tribes.

SUMMARY: The Bureau of Indian Affairs (BIA) announces the availability of $581,000 in grant funds to continue the Self-Governance Demonstration Planning Grant Program in FY 1991. Of the amount appropriated by the Congress, $125,000 has been earmarked for the Lummi Tribe in Washington for the continuation of its educational component relative to the Self-Governance Demonstration Project. The remaining $456,000 is available for distribution to other federally recognized tribes which meet the criteria established later in this announcement; except that, the following tribes may receive an amount not to exceed $20,000 per eligible tribe, for the negotiation of a Self-Governance Demonstration Project in FY 1991.

FY 1991 Negotiating Grantees

Mescalero Apache Tribe
Shoshone-Paiute Tribes of the Duck Valley Reservation
Ely Colony
Leech Lake Band
Cheyenne River Sioux
Port Gamble

The approximatley $336,000 of funds remaining available after the above referenced needs have been met, will be available for distribution as continuation grants to the ten tribes particpating in the Self-Governance Demonstration Planning Grant Program for the first time in FY 1990.

FY 1991 Continuation Grantees

Kawerak, Inc.
Siletz Tribe
Tanana Chiefs Conference, Inc.
Sac and Fox Nation
Duckwater Shoshone Tribe of Nevada
Sisseton-Wahpeton Sioux Tribe
Makah
Grand Traverse Band
Shoshone-Bannock Tribe
Lower Elwah Tribe

Due to limited appropriations, the ten continuation grantees must compete within that group for funding in the same manner in which they competed for their initial grants. The only difference is that the continuation grantees do not compete with all tribes nationally. Only those tribes having successfully completed a prior year's Self-Governance Demonstration Plannng Grant are eligible to apply.

FOR FURTHER INFORMATION CONTACT: William Lavell (202) 208–5116 or Verne Duus (202) 208–4839, U.S. Department of the Interior, Office of Self-Governance, 1849 C Streets, NW. (MS–4140–MIB) Washington, DC 20240.

SUPPLEMENTARY INFORMATION: *A. Purpose of the Program:* The purpose of the program under this announcement is to continue the Self-Governance Demonstration Planning Grant Program begun in FY 1988. In FY 1991, this program will provide a maximum grant of $20,000 to each of six tribes (see list of FY 1991 Negotiation Grantees in the previous section) to negotiate a Self-Governance Demonstration Project agreement reflecting tribally determined budgetary and programmatic priorities as authorized by title III of Public Law 93–638, as amended. It will also allow for continuation grants to the ten tribes that participated in the program in FY 1990 for the first time (see list of FY 1991 Continuation Grantees in the previous section).

The Self-Governance Demonstration Planning Grant Program is designed to allow tribes to plan for the exercise of greater degrees of self-determination by assuming more and more control of BIA programs and services through future agreements negotiated with the Secretary of the Interior or his designated representative. The grant allows tribes to gather information to determine the current types and amounts of programs, services, and fiscal resources available within its service area and to plan what types, amounts of programs, services, and fiscal resources should be available to its members rather than be limited to providing the same programs, services, or functions as the BIA would provide. Awards will be made pursuant to the appropriations received through Public Law 101–512, the Interior and Related Agencies Appropriations Act of 1991.

Planning grants will be awarded on a competitive basis to those tribes meeting the eligibility criteria and other provisions as contained in this announcement. Applications not meeting all provisions of this announcement will be considered non-repsonsive and will not be reviewed for funding; e.g., an application which does not include a tribal council resolution will be considered non-responsive. There shall be no appeal from a determination by the BIA regarding the non-responsiveness of any application recieved.

B. Eligibility Criteria: To receive a planning grant under this announcement, a continuation grantee must:

1. Make a request for a planning grant by resolution of its governing body which contains: (a) A statement indicating a desire to participate in the Self-Governance Demonstration planning grant for an additional year; (b) a commitment to develop a plan for consolidated contract or other type of agreement for direct funding of BIA programs, services or functions;

2. Have successfully operated a Self-Governance Demonstration Planning grant in the previous year.

3. Have operated three or more contracts without significant or material audit exceptions (material audit exception as used here means audit findings which can result in criminal action against a responsible tribal official or bills of collection being issued against a tribe); and

4. Must furnish an organization-wide or single audit report as prescribed by Public Law 98–502, the Single Audit Act of 1984, for FY 1989 which contains no significant or material audit exceptions (material exceptions here means the same as in item 2, immediately above, and audit findings requiring a corrective action plan as prescribed by the Single Audit Act, Pubic Law 98–502).

The FY 1991 Negotiating Grantee tribes may request, and receive, an amount not to exceed $20,000 each to negotiate a Self-Governance Demonstration agreement. This is a noncompetitive award. The funds may be used for legal advice, travel costs, or any other expense necessary to negotiate an agreement so long as such costs are reasonable, allocable, and allowable under the terms proposed by the agreement and in accordance with OMB Circular A–87, Cost Principles for State and Local Governments.

C. Grant Period: Duration of planning grants awarded under this announcement shall be for a period of six months or less.

D. Funds Available: The BIA has an FY 1991 appropriations of $581,000 for the Self-Governance Demonstration Planning Grant Program in FY 1991. This will alow for the awarding of six negotiation grants, not to exceed $20,000 each, as well as for $336,000 in FY 1991 continuation planning grants to the ten grantee tribes competing for continuation Self-Governance Demonstration Planning Grants. The remaining $125,000 of FY 1991

appropriations received are congressionally directed to the Lummi Indian Tribe for the continuation of its educational program relative to the Tribal Self-Governance Demonstration Project. Should additional funds become available in FY 1991, the BIA will amend this announcement and establish separate application criteria, processes, and procedures for its use. Additionally, should these Self-Governance Demonstration Grant Program funds be used for other purposes; e.g., used in a manner commensurate with the FY 1991 Interior and Related Appropriations Act but not in accordance with the announcement, the BIA will notify the general public of its intent for use of the funds through further publication in the Federal Register.

E. Application Process: Applications submitted for funding under the competitive portion of this announcement shall be on an SF–424, and, as may otherwise be provided by OMB Circular A–102. In addition to a tribal council or governing body resolution, an applicant shall submit a narrative description of planning grant activities with a line item budget and budget justification for FY 1991 activities as well as an interim report of progress made with the resources made available in FY 1990. The FY 1990 interim report will speak to problems encountered as well as accomplishments made by the applicant grantee. In formulating its proposal, a tribe may use the following as guides for the effort:

1. Continuation Grantees: The governing body of a continuation grantee for the purposes of this announcement is authorized to:

(a) Conduct activities which provide the tribe with a greater understanding of BIA programs and which may lead the tribe to a position where it is better able to plan, conduct, consolidate, and administer programs, services, and functions authorized under the acts of April 16, 1934 (25 U.S.C. 452; 48 Stat. 596) and November 2, 1921 (25 U.S.C. 13; 42 Stat. 208);

(b) Conduct activities and gather information which provides the tribe with a greater understanding of BIA programs and which may lead the tribe to a developmental level where the tribe determines that it is desirable to redesign BIA programs, activities, functions, or services and to reallocate funds for such programs, activities, and services; and

(c) Conduct activities and gather data which may enable the tribe to identify and specify the services to be provided, the functions to be performed, and the respective responsibilities of the tribe and the BIA under a proposed Self-Governance Demonstration Project agreement.

2. Negotiation Grantees: In proposing terms for an agreement:

(a) A tribe is entitled to receive funds for any programs, services, or functions in an amount equal to the amount the tribe would be eligible to receive under contracts and grants authorized by Public Law 93–638, as amended, including direct program costs and indirect costs, and for any funds which are specifically related to the provisions of services and benefits of the BIA to the tribe and its members, provided, however, that funds for trust services to individual Indians are available under any written agreement to the extent that the services would have been provided by the BIA and are provided to individual Indians by the tribe;

(b) A tribe may not receive funds under a self-determination contract for any program, service, or function to be provided or performed under a proposed agreement under this announcement;

(c) A tribe submitting a proposal for an agreement as a deliverable is not obligated to enter into an agreement with the BIA. The proposal merely serves as a starting point for negotiations between the tribe and BIA for arriving at an agreement;

(d) A tribe may retrocede all or any portion of a direct funding agreement after completing the first year of the agreement;

(e) Participation by a tribe in the planning grant program or a subsequent Self-Governance Demonstration Project agreement will not (i) affect, modify, diminish, or otherwise impair the sovereign immunity from suit enjoyed by the tribe, or (ii) authorize, require, or permit the determination of any existing trust responsibility of the United States with respect to the tribe or its members.

F. Application Review and Approval Process: Applications submitted in response to this announcement for continuation grantees will be subject to competitive review and evaluation. An independent review panel, appointed by the Assistant Secretary—Indian Affairs, will evaluate applications against the criteria and the terms and conditions contained in this announcement, including any statutory or regulatory requirements.

Incomplete applications or applications which do not conform to this announcement will not be reviewed; i.e., an application lacking a single agency audit report. Such applications will be returned to sender as non-responsive and the applicant shall have no appeal rights. All other decisions made by the BIA regarding the applications are appealable under the provisions of 25 CFR part 2.

Applications will be reviewed and rated as follows:

1. The goals/objectives of the grant are scheduled and measurable and are consistent with the purpose of this announcement; (35)

2. Grant objectives are fully and clearly described and reflect the needs of the tribe and its members; (20)

3. The grant objectives can be accomplished with the resources requested and/or available and the application indicates who will accomplish each objective; (15)

4. The application contains evidence of capability and qualifications, i.e., resumes and position descriptions of key project staff are a part of the application; and (15)

5. A line item budget is accompanied by a detailed justification for each expenditure; and the cost of the expenditure is reasonable and allocable to the proposed agreement and allowable in accordance with OMB Circular A–87, Cost Principles for State and Local Governments. (15)

G. Submission of Competitive Applications:

1. The closing date for competitive applications submitted for this announcement is March 13, 1991.

2. Applications may be mailed or hand-delivered;

a. Applications which are mailed must be postmarked no later than midnight on March 13, 1991;

b. Applications which are hand-delivered, must be received at the address and room referenced below, no later than the close of business on March 13, 1991;

c. Late applications will not be considered for funding;

3. Applications shall be mailed or hand-delivered to: U.S. Department of the Interior, Assistant Secretary—Indian Affairs, Attention: Office of Self-Governance, 1849 C Street, NW., MS–4140–MIB, Washington, DC 20240.

H. Submission and Review of Non-Competitive Negotiation Applications:

Grantees submitting an application for the negotiation grants on a non competitive basis shall use the SF–424, Application for Federal Assistance and include a complete line item budget, not to exceed $20,000, and written budget justification which outlines how the request for funding was derived. These applications may be submitted at any time during the fiscal year but before August 31, 1990, in order to give the BIA time to review and act on the applications and award negotiation grants before fiscal yearend.

Applications received for the negotiation grants, not to exceed $20,000 each, will be reviewed by staff within the Division of Self-Determination Services in accordance with cost principals found in A–87, Cost Principals for State and Local Governments. Applications submitted under this portion of the announcement shall be submitted to the address listed in item F.3., above.

Eddie F. Brown,

Assistant Secretary—Indian Affairs.

[FR Doc. 91–3107 Filed 2–8–91; 8:45 am]

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federal register

Monday
February 11, 1991

Part V

Department of Health and Human Services

Social Security Administration

20 CFR Part 416
Supplemental Security Income; Determining Disability for a Child Under Age 18; Final Rule With Request for Comments

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Social Security Administration

20 CFR Part 416

[Regulations No. 16]

RIN 0960-AD09

Supplemental Security Income; Determining Disability for a Child Under Age 18

AGENCY: Social Security Administration, HHS.

ACTION: Final rule with request for comments.

SUMMARY: These amendments revise the disability evaluation and determination process for Supplemental Security Income (SSI) claims of children based on disability. The revisions are designed to comply with the February 20, 1990, U.S. Supreme Court ruling in the case of *Sullivan* v. *Zebley*, ___U.S.___, 110 S. Ct. 885 (1990). In "Zebley", the Supreme Court invalidated the use of a medical "listings-only" approach to evaluating such childhood disability claims and required the use of an individualized functional assessment of children whose impairments did not meet or equal the severity of listed medical impairments. The changes incorporate into the disability determination process for children concepts and criteria reflecting current knowledge in the field of childhood disability and functioning.

Although these regulations are being published as final rules, we are asking for comments concerning these rules from members of the public. After the end of the comment period, we will carefully consider any comments we receive in order to determine whether any changes are necessary.

DATES: These final rules are effective on February 11, 1991; comments must be received on or before April 12, 1991.

ADDRESSES: You may submit comments to the Commissioner of Social Security, Department of Health and Human Services, P.O. Box 1585, Baltimore, Maryland 21203, or deliver them to the office of Regulations, Social Security Administration, 3-B-4 Operations Building, 6401 Security Boulevard, Baltimore, Maryland 21235, between 8:00 a.m. and 4:30 p.m. on regular business days. Comments may be inspected during these same hours by making arrangements with the contact person shown below.

FOR FURTHER INFORMATION CONTACT: Martin Sussman, Legal Assistant, Office of Regulations, Social Security Administration, 6401 Security Boulevard, Baltimore, Maryland 21235, telephone (301) 965-1758.

SUPPLEMENTARY INFORMATION:

History

Provisions for benefits for disabled children were part of the original 1972 legislation establishing the SSI program, which became operational in 1974. The Social Security Act (the Act) provides the same definition of disability for adults under the SSI program under title XVI of the Act as it does for workers and children of workers under the disability insurance (DI) program under title II of the Act.

The Act, at section 1614(a)(3)(A), defines disability for adults as the inability "to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." The law further provides, at section 1614 (a)(3)(B), that an adult (that is, a person age 18 or older) will be considered disabled, "only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy * * *."

The definition of disability for children is contained in a parenthetical statement at the end of section 1614 (a)(3)(A). The Act provides that a child (that is, a person under the age of 18) will be considered disabled for purposes of eligibility for SSI, "if he suffers from any medically determinable physical or mental impairment of comparable severity" to that which would make an adult disabled.

Under the Social Security Administration (SSA) regulations, the decision process for determining if an adult is disabled is different in concept from the process we formerly used for children. Regulations §§ 404.1520 and 416.920 set out a five-step sequential evaluation process for determining disability in adults, which considers in turn:

1. Whether the adult is doing substantial gainful activity;

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

3. Whether, if the impairment(s) is severe, it meets or equals in severity an impairment listed in appendix 1 of subpart P of the Regulations part 404;

4. Whether, in the presence of a severe impairment or combination of impairments, the individual retains the capacity to do his or her past relevant work, considering his or her residual functional capacity; and

5. Whether, if past relevant work is precluded, the individual retains the capacity to do any other work, considering the individual's residual functional capacity and the vocational factors of age, education, and work experience.

We published the regulation that was at issue in the "Zebley" case at § 416.923 at 45 FR 55621 (August 20, 1980) and redesignated it to § 416.924 at 50 FR 8729 (March 5, 1985). Under this section, we determined whether a child was disabled by comparing the child's impairment(s) to those in the medical listings, as in the third step of the process for adults. If the child's impairment(s) met, or was equivalent in severity to, one in the listings, we determined that the child was disabled, as long as he or she was not engaging in substantial gainful activity and met the 12-month duration of impairment requirement. If the child's impairment(s) did not meet or was not equivalent to, one in the listings, we determined that the child was not disabled; we did not provide additional evaluation steps for children, as we do for adults. Thus, SSA defined the comparable severity standard contained in the law in terms of whether a child's impairment(s) met or equaled in severity those in the listings.

Part A of the Listing of Impairments in appendix 1 of subpart P of the Regulations part 404 describes, for each of the major body systems, impairments that are considered severe enough to prevent a person from doing any gainful activity, as opposed to substantial gainful activity. Part B of the listings provides criteria solely for the evaluation of impairments of children. Part B is used first in evaluating claims of children. The criteria in part A normally apply to adults, although they can be used for a child if the child's impairment(s) is not found to meet or equal in severity the criteria in part B or is not addressed in part B.

Sullivan v. Zebley

On February 20, 1990, the Supreme Court, in the case of *Sullivan* v. *Zebley*, decided that SSA's regulations implementing the law for evaluating disability in children did not adequately reflect Congressional intent. The Court held that the "listings-only" approach SSA had used to evaluate the disabilities of children did not carry out

the "comparable severity" standard in the law, in that the listings were set at a level of severity stricter than the level at which an adult worker can be found disabled and our former policies did not provide for an assessment of overall functional impairment.

We read the Supreme Court's decision as holding that children are entitled to an "individualized functional assessment" as part of SSA's disability determination process, comparable to adults who have impairments that do not meet or equal the listings and receive such an individualized assessment. The Court found that, whereas adults who do not qualify under the listings still have the opportunity to show that they are disabled at the last steps of the evaluation sequence, no similar opportunity exists for children, who are denied benefits even if their impairments are of comparable severity to ones that would actually disable adults. The Court concluded that, although the vocational analysis used in adult claims is inapplicable to childhood cases, this does not mean that a functional analysis cannot be applied to them.

Since late February we have not denied any childhood SSI claims or terminated benefits based on findings that a child fails to meet or equal the listings. Since May, 1990, we have been adjudicating cases using an interim standard pursuant to an order of the District Court for the Eastern District of Pennsylvania, the court where the "Zebley" litigation was originally brought. The interim standard provides for consideration of a child's functioning for the determination whether the child's impairment(s) is equivalent in severity to a listed impairment and for the determination based on an individualized functional assessment whenever a child does not meet or equal a listing. This regulation will replace the interim standard.

Method Used To Revise the Childhood Disability Rules

On March 23, 1990, the Department of Health and Human Services and SSA announced that experts in child development and childhood disability would be asked to meet with SSA representatives and assist in devising the new regulations by supplying input based on their individual expertise. The experts were chosen to represent a wide range of areas in the assessment of child development and childhood disability, including general pediatrics, developmental genetics, developmental pediatrics, infant development, family and support systems, behavioral pediatrics, pediatric psychiatry, pediatric neurology, child psychology, pediatric special education, home and community care, physical and occupational deficits, early childhood education, pediatric rehabilitation, learning disorders, chronic illness and somatics, and communication disorders. We met with the experts in meetings held in Washington, DC, on April 16 and 17, May 3, 4, and 5, and June 28 and 29, 1990. The meetings were open to the public.

We also asked other people for their ideas on how to evaluate childhood disability. We solicited comments and suggestions from other experts who were unable to attend our meetings. These experts, who included individuals we selected and individuals who were recommended to us by advocates and others, or who offered their help to us, further broadened our base of knowledge in the fields of pediatric medicine and childhood disability.

We also sought input from advocacy groups as we revised the rules. From the outset of the process, before we met with the experts or began drafting these rules, we shared and exchanged ideas with the advocacy community. In March 1990, we met with more than two dozen groups interested in childhood disability to get their input on what we should consider in developing our new standard. We have also corresponded with many of these groups and other advocacy groups concerning our progress. In addition, we were assisted as we drafted our new policies by representatives from four advocacy groups: Community Legal Services, in Philadelphia (the attorneys who represented the "Zebley" plaintiff classy), the Association for Retarded Citizens of the United States, the Mental Health Law Project, and the National Senior Citizens Law Center.

Within the SSA community, we solicited comments and advice from our own regional office staffs and the State agencies, the agencies in the individual States that make disability determinations under the Act. Finally, as a consequence of our outreach efforts, we also received several valuable comments from organizations and individuals who were aware of the "Zebley" decision and our revision of the regulations.

Explanation of Revisions

The final regulations replace our prior rules for deciding disability in childhood cases under SSI and the interim standard that we have been using in these cases since May, 1990. As required by the Supreme Court's ruling in "Zebley", they accord each child whose impairment(s) does not medically meet or equal a listing an opportunity to receive an individualized assessment of his or her functioning. The new rules provide two steps at which a child's functioning will be assessed. First, they provide a new policy for considering functioning at the listings equivalence step. Second, they ensure that disability evaluations of children under the SSI program include a process for evaluating childhood disability that is not based solely on listing-level severity. They provide an additional step beyond the listings at which we may determine that children with severe impairments that do not meet or equal (medically or functionally) a listing are disabled based on an assessment of their functioning that demonstrates that they have impairments of "comparable severity" to impairments that would disable adults.

As a result, the new sequence for children is:

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

2. Whether the child's impairment or combination of impairments is severe;

3. Whether the child has a medically determinable impairment(s) that meets or equals in severity a listing in appendix 1 of subpart P of part 404 or, if not, whether the functional consequences of the child's impairment or combination of impairments functionally equal a listing; and

4. Whether the child's severe impairment(s) so limits the child's ability to function in an age-appropriate manner that the limitations are comparable in severity to those that would disable an adult.

It is still possible for children to have impairments equal in severity to listed impairments based solely upon medical findings. Because the longstanding concepts of meeting or equaling a listing based upon medical findings permit us to find many claimants disabled on medical grounds alone, we have retained these longstanding procedures. However, we have also expanded and clarified our prior rules for making determinations of equivalence.

We have also removed our prior medical improvement rules for children, formerly in § 416.994(c), and have added a new medical improvement regulation for children, § 416.994a, to be used in determining whether childhood disability continues. Because the former rules in § 416.994(c) were based on our prior listings-only test, we are replacing them. The new section is modeled after the adult rules and takes into account the new childhood disability rules in §§ 416.924 and 416.924a through 416.924e.

Other Changes

We have revised some of the rules in Subpart I that are relevant to children so that they explicitly refer to children. In addition to the new rules in § 416.924, which provide a sequential evaluation process for children and a new interpretation of the statutory definition of disability for children, we have also added new rules and language that were necessary to address issues specific to the evaluation of disability in children or to provide clarification of existing policies in terms that are more meaningful to the evaluation of children's cases.

Inclusion of adult claimants in separate publications of the **Federal Register**. We believe that the Supreme Court's analysis of our equivalence policies in "Zebley" addressed policy issues that do not necessarily have to be confined to children's cases, and that the new functional equivalence policy we have developed for children could apply to adult claimants as well. Therefore, we have decided to extend the revisions to determinations of equivalence for adults under titles II and XVI by publishing separately a notice of proposed rulemaking (NPRM) that will propose to extend the provisions to all other adults under titles II and XVI. The NPRM will propose to consolidate the provisions of the two regulations into identical revisions under Parts 404 and 416 of this chapter, to establish a uniform standard for all individuals who apply for and receive disability benefits under the Act.

Summary of Specific Provisions

From our public meetings with the experts and our discussions with other individuals and organizations, we received many thoughtful comments and suggestions on the standard and criteria we should use to evaluate disability in children. The comments were very helpful to us as we developed these regulations.

The suggestions had certain common elements. There was considerable support in the comments for the principle of assessing a child's overall functioning in all domains—that is, broad spheres of physical and mental functioning—measured by how well the child can do age-appropriate activities. Many commenters were concerned about the need to consider the setting in which the child resided, such as the family, and the need to consider both the positive and negative influences of the child's environment (including family, school, and community) on the child's medical status, development, and functioning. Many comments also emphasized the importance of gathering "multidisciplinary" evidence—that is, evidence from several expert sources in different disciplines in addition to medicine—as well as information from parents and others who have knowledge of a child's day-to-day functioning.

A frequent comment concerned the need to address the problem of assessing disability in infants, who are often difficult to evaluate because they exhibit a narrow range of medical findings and behaviors and cannot be tested or be precisely diagnosed. Many people urged us to create special rules for the youngest children which would give the benefit of the doubt to those infants who exhibit signs of disability but who are as yet too young to be specifically evaluated. Most commenters suggested that we also provide special rules for reevaluating the claims of children whom we found disabled in this manner when the children became old enough for complete assessment.

A related idea, which arose from our discussions with the group of experts, suggested creating a "screen"—a list of specific conditions or specific functional limitations or other descriptors of obvious disability which, if met, would presumptively establish disability. As we explain below, our revision of the equivalence rules derives in part from this recommendation.

We have given careful consideration to the suggestions made by all those from whom we solicited comments and who offered us their thoughts and assistance. We have used as many of their ideas as we could within the framework of the Act, including the suggestion to provide rules that would give special consideration to the problems of evaluating disability in infants.

However, we have not included all of the suggestions from the experts, the advocacy community, the State agencies, our regional offices, and others. Throughout the process of drafting these rules, we have been mindful of the law, which states that children are disabled if they "suffer from" an impairment of "comparable severity" to that which would disable an adult; in our view, some suggestions addressed areas of social policy beyond what is permissible under the law.

The new rules relating to disability in infants are an example of a change we could make. Infants—especially infants less than 6 months old—can be very difficult to evaluate because they do not always exhibit clear medical or functional findings. Even when such infants do exhibit signs of limitation or deficits in functioning, it is often difficult to diagnose the specific medical cause of their problems and, hence, to predict the course of the impairment for the purpose of establishing whether the duration requirement will be met. Our prior policy required infants to prove that they were disabled, just as any claimant has to do. However, because of the unique problems in evaluating infants, we sometimes had to defer decisions in these cases; that is, hold them until the children were older and could be more easily evaluated.

Consistent with the recommendations and based on our operating experience with infant claims, we have established new rules for infants that are consistent with the law and are comparable to our longstanding policies for evaluating disability in adults. Our new rules on equivalence based on function in § 416.926a, and the recent publication of Listing 112.12 of the childhood mental listings, a listing specifically for infants from birth to age 12 months, provide a means by which infants may establish both that they have medically determinable impairments and that they are disabled based on their functional impairment. Our case experience has shown that infants who demonstrate the kinds of functional deficits that will be required to establish disability under new Listing 112.12, or to establish functional equivalence to that listing under the new rule in § 416.926a, are likely to continue to demonstrate that they are disabled when they are older.

For similar reasons, we have established new guidelines in § 416.924b(d) for considering age in children analogous to the consideration given to age in adults, so that infants under 12 months of age are considered in much the same way as adults who are closely approaching retirement age (i.e., age 60 and older). Just as the adult rules recognize advancing age as an increasingly important factor in determining disability, so that older adults may be found disabled with a lesser degree of functional limitations than younger adults, the new childhood rules provide that, the younger the child, the greater the impact of impairments is likely to be on the child's overall ability to develop and function. This rule, too, is based on sound principles of pediatrics and our operating experience in childhood cases.

With respect to records from schools, early intervention and similar programs, if a child has been assessed under another program that serves children with disabilities, we will make every reasonable effort to obtain any assessments and records of the child's functioning (e.g., an Individualized

Education Plan) that may be useful and available from that program; for example, from Head Start, which serves a percentage of children with handicapping conditions; from the program for Children with Special Health Care Needs of the Maternal and Child Health program; from Part H early intervention programs for children from birth to age 2, inclusive, under the Education for All Handicapped Children Act (EHA); and from public school records required under Part B of the EHA for all school-age children with qualifying handicapping conditions. We will use these records and assessments to help us determine whether the child may be found disabled under title XVI.

The following is a summary of the major rules we are adopting in this regulation, as well as a detailed explanation of the content and intent of the rules. Following the summary of the major rules, we provide a brief summary of other changes we have made throughout subpart I to ensure conformity throughout our SSI disability regulations.

It should be noted that these rules provide only new policies and clarifications of existing policies in response to the "Zebley" decision. They must be read in the context of our existing rules for determining disability. For instance, the evaluation of functioning includes consideration of all relevant evidence, including evidence of symptoms such as pain, which must be evaluated in accordance with our existing rules.

General Note on Style

The childhood disability regulations are written in the first and second persons, addressed from us to the children who claim to be disabled, instead of their parents or other appropriate adults. Even though addressing a regulation to infants and very young children can appear illogical, it is consistent with our regulatory terminology and style, and less cumbersome than the language that would be required to address these regulations to the adults who will ordinarily be responsible for assisting the children in their claims.

However, should any member of the public believe that the terminology and style we have used in these regulations creates an ambiguity or might present a problem in the application of particular sections of these regulations, we would appreciate such concerns being brought to our attention.

Section 416.902 General Definitions and Terms for This Subpart

We have added definitions for the terms "adult" and "child" to this section. We derived the definition of a child as "a person who has not attained age 18" from section 1614(a)(3)(A) of the Act, which confines the childhood definition of disability to children "under the age of 18." This is the same definition we have always used in subpart I of these regulations.

Because we provide a definition of the term "child" at the beginning of subpart I, we believe that it is unnecessary to repeat the phrase "a child under age 18" throughout the remainder of the subpart, as we did in our prior regulations. We simply use the word "child."

We have not changed the meaning of the term "you" in this section. We believe that the current definition ("the person who has applied for benefits or is receiving benefits") is sufficient to convey the meaning of the term, which includes both the child for whom a claim has been filed and the person who has filed the claim for the child.

Section 416.924 How We Determine Disability for Children

We have completely revised this section. In paragraph (a), we restate the statutory definition of disability for children; that is, an impairment or combination of impairments that is of comparable severity to an impairment or combination of impairments that would disable an adult. We then provide successively more detailed definitions of "comparable severity."

The term "comparable severity" means that a child's physical or mental impairment(s) so limits his or her ability to function independently, appropriately, and effectively in an age-appropriate manner that the impairment(s) and its consequent limitations are comparable to those that would disable an adult. We then explain that this means that a child's impairment(s) must substantially reduce or, in the case of infants from birth to the attainment of age 1, be expected to substantially reduce his or her ability to grow, develop, or mature in an age-appropriate manner.

The three subparagraphs (a)(1) through (a)(3) describe different ways of applying this definition and are linked to different ages, using terms that we later define in § 416.924a(c). Thus, (a)(1) is applicable to the evaluation of infants and young children, and so is couched in terms of "developmental milestones"; (a)(2) is applicable to school-age children, and so is couched in terms of "activities of daily living"; and (a)(3) is applicable to older adolescents, and so is couched in terms of the acquisition of skills needed to assume adult roles. We do not intend these general distinctions to be rigidly applied. It is often appropriate to speak of developmental milestones in younger school-age children, and of activities of daily living in preschoolers; clearly, both activities of daily living and the acquisition of skills needed to assume roles reasonably expected of adults are meaningful and important to the evaluation of impairment in adolescents.

Paragraphs (b) through (f) introduce the new sequential evaluation process for children. As in the adult sequence, we consider all available relevant and material evidence in the case record at each step, and all impairments a child alleges, both singly and in combination. Likewise, each step of the sequence except the last provides two alternatives: Either a determination or decision that the child is or is not disabled, in which case we do not continue in the sequence; or no determination or decision can be made at that point, in which case we proceed to the next step. At the last step of the sequence, a determination or decision must be made.

The sequence is as follows:

1. Is the child engaging in substantial gainful activity?

Inasmuch as the basic statutory definition of disability requires an inability to engage in substantial gainful activity, no individual—including a child—may be found disabled if he or she is actually working at this level. In paragraph (c) we provide that, as in adult claims, we will not consider a child's impairments, no matter how severe they are, if the child is engaging in substantial gainful activity. The same rules for determining whether an adult is engaging in substantial gainful activity, which provide for consideration of such things as subsidies, impairment-related work expenses; and other special considerations in determining the level of earnings, also apply to children.

If a child is engaging in substantial gainful activity, we will find the child not disabled. If not, we will proceed to the next step in the sequence.

2. Does the child have a "severe" impairment or combination of impairments?

If a child has an impairment or combination of impairments that causes more than a minimal limitation in his or her ability to function, we will find that the child has a severe impairment(s) and go on to the next step in the process. If we find that the child has no more than

a minimal limitation in his or her ability to function, we will find the child not disabled.

We have added a "severe" step to the childhood sequence to make it more comparable to the sequence used for adults. Prior to "Zebley", we used a relatively simple process to determine disability for children—whether the child was engaging in substantial gainful activity and, if not, whether his or her medically determinable impairment met or equaled in severity an impairment in the listings. Because this process was not comparable to the evaluation sequence used for adults, the Supreme Court found it lacking. Adding a "severe" step makes the evaluation processes more alike and, we believe, comports with the spirit of the "Zebley" decision to evaluate children comparably to adults. In adult cases, we assess residual functional capacity only after we have found that the person has a severe impairment(s). Likewise, we will first determine that a child has an impairment(s) that is severe before we do an individualized functional assessment.

We want to stress, however, that by including this policy in the new childhood rules, we do not intend to deny benefits to any child who may fit within the statutory definition of disability, only to provide a more efficient process. As the Supreme Court noted when it upheld the validity of the severity step in the adult sequence in the case of *Bowen* v. *Yuckert:*

> The severity regulation increases the efficiency and reliability of the evaluation process by identifying at an early stage those claimants whose medical impairments are so slight that it is unlikely they would be found to be disabled even if their age, education, and experience were taken into account. Similarly, step three (the "meets/equals" step of the adult sequence) streamlines the decision process by identifying those claimants whose medical impairments are so severe that it is likely they would be found disabled regardless of their vocational background.
>
> *Bowen* v. *Yuckert*, 482 U.S. 137, 153 (1987).

We believe that the same basic principles apply to childhood disability claims, and have therefore provided both a listings step which identifies the most severely disabled children and a step that identifies those children whose impairments are so slight that it is unlikely that they would be found disabled were we to proceed to the end of the sequence. We will not use the not severe step to disqualify any child who may fit within the statutory definition of disability without determining whether he or she has an impairment(s) of comparable severity to an impairment(s) that would disable an adult. Only those claimants with slight abnormalities that do not significantly affect the ability to function independently, appropriately, and effectively in an age-appropriate manner can be denied benefits without undertaking the analysis associated with an individualized functional assessment.

As the Supreme Court noted in "Yuckert," both the listings step and the not severe step provide a method for determining the most obvious cases. In childhood claims, the considerations are the same at both steps. Just as we consider both medical and functional evidence at the listings step to determine whether a child's impairment(s) is so severe that a finding of disability can be made without the need for an individualized functional assessment, we will use the same considerations to decide whether the child's medically determinable impairment(s) is so minimal that it could not possibly be disabling.

If a child does not have a "severe" impairment or combination of impairments, we will find the child not disabled. If the child has a "severe" impairment, we will proceed to the next step of the sequence.

3. Does the child have a medically determinable impairment(s) that meets a listing in appendix 1 of subpart P of part 404? If not, does the child have an impairment or combination of impairments that is equivalent in severity to any impairment in the Listing of Impairments, including an impairment or combination of impairments that is functionally equivalent to a listing?

In paragraph (e) we provide that, if a child has an impairment that meets a listing, or an impairment(s) that equals a listing, including the duration requirement, we will find the child disabled. If not, we will proceed to the final step in the sequence.

4. Does the child have an impairment or combination of impairments that so limits his or her physical or mental abilities to function independently, appropriately, and effectively in an age-appropriate manner that the limitations are comparable in severity to those which would disable an adult?

Paragraph (f) introduces the new term "individualized functional assessment" (IFA) to the regulations. We derived the term from language in the "Zeblev" decision to provide a means for describing the assessment of functional limitations and abilities in children. (We provide detailed rules for doing IFAs in a new regulation, § 416.924a.) This paragraph provides that we will do an IFA and use it to decide whether the child has an impairment(s) of comparable severity to an impairment(s) that would disable an adult.

Paragraph (f)(1) provides that if a child has such an impairment or combination of impairments, and the impairment(s) meets the duration requirement, we will find the child disabled. Paragraph (f)(2) provides that, if the child does not have such an impairment or combination of impairments, or the child has such an impairment or combination of impairments but the impairment(s) does not meet the duration requirement, we will find the child not disabled. These steps are intended to provide criteria comparable to the steps in the adult sequence for adults who do not have impairments that meet or equal the listings but who may nevertheless be disabled.

We also provide additional detailed guidance throughout §§ 416.924a through 416.924d, regarding the role of age in the determination process and about age-appropriate skills, abilities, and behaviors. Because the evaluation of impairments in children, like adults, is necessarily complex, we provide detailed guidelines for implementing the final step using the individualized functional assessment in new regulation § 416.924e.

Section 416.924a Individualized Functional Assessment for Children

In this section, we describe generally the purpose of the individualized functional assessment for children and how we will do the assessment. We explain that the assessment is to be based on all relevant evidence in the case record from both medical and nonmedical sources. We reaffirm the important principle that evaluation of the evidence should result in an assessment of a child's functioning on a longitudinal basis—that is, over time.

In paragraph (b), we give examples of some of the types of evidence we consider in doing an individualized functional assessment. We explain that medical evidence consists of symptoms, signs, and laboratory findings. We also provide guidance, modeled on our discussions in 112.00D of the childhood mental listings about determining the validity and reliability of formal testing, that the results of standardized testing should be consistent with the remainder of the record, and that, ideally, any medical findings in the case record should be based on the medical source's own findings and consideration of information from the child's parents or other knowledgeable individuals. We also state that parents, relatives,

teachers, school records, and the records of early intervention and other, similar programs, are important sources of information about a child's day-to-day functioning.

We recognize that there are definitions of disability for children in three other programs administered by the Federal government, specifically in the Developmental Disabilities Act and in parts B and H of the Education of All Handicapped Children Act (EHA). We were unable to adopt any of these other definitions because none of them could serve the particular program needs generated by the Supreme Court's mandate that SSA do an individualized functional assessment for the population of children served by the SSI program. For the same reasons, we are unable to adopt the disability determinations of other programs. Indeed, we have a general policy, set forth in regulation § 416.904, that we must make a disability or blindness determination based on Social Security law. A decision by any nongovernmental agency or any other governmental agency about whether an individual is disabled or blind is based on its rules and is not our decision about whether the individual is disabled or blind. Therefore, a determination made by another agency that a child is disabled or blind is not binding on us. However, we recognize that the other definitions reinforce the concept that an individualized functional assessment is a procedure resulting in necessary descriptive information about a child, and that this information is vital to making decisions about the presence or absence of disability according to SSA's definition of disability.

The Developmental Disabilities Act definition is similar to the title XVI definition in that it defines a developmental disability as (1) severe, (2) attributable to a mental or physical impairment or a combination of both mental and physical impairments, and (3) functionally-based, resulting in substantial limitations in three of seven major life activities (e.g., self-care, mobility). However, the definition differs from the title XVI definition in that it requires (1) a chronic disability that is likely to continue indefinitely, that (2) is manifested before age 22, and that (3) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated. In contrast, the title XVI definition requires only 12 months of disability with onset prior to age 18, and is not limited to conditions that require extensive, interdisciplinary treatment.

Similarly, the parts B and H definitions in the EHA, although congruent in some ways with our proposed definition, are in other ways incongruent and, thus, unusable in our program. The definition of "handicapped children" under Part B of the EHA is a set of categorical definitions for school-age children, such as speech impaired, mentally retarded, and seriously emotionally disturbed. Although these categories cover the functionally-based impairments that we would anticipate in children applying for benefits under title XVI, there are other factors that make the part B definition unusable: (1) Part B is an entitlement program, whereas title XVI is a means-tested program; while all school-age children with qualifying handicapping conditions are to be served under part B, only those children who meet both the disability and income and resource tests under title XVI may become eligible for SSI benefits; and (2) the categorical definitions of part B do not provide a usable framework for evaluating the ranges of functional limitations produced by either developmental or physiological disorders.

Finally, part H of the EHA, which provides for early intervention services from birth through age two, inclusive, identifies "infants and toddlers with handicaps" in three separate groups: Children who are already experiencing developmental delays in one or more functional areas of development (e.g., cognitive, physical); children who have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay; and, at a State's discretion, children who are at risk of having substantial developmental delays if early intervention services are not provided. Although the functional descriptors for the first part H group may be congruent with the proposed definition for evaluation of children under title XVI, there is no standard as to how serious the delay must be in order for a child to qualify for services. Although the description of the second part H group could apply to infants for whom applications are filed under title XVI, the last definition is not usable in the formulation of new disability rules for children under title XVI because it addresses the possibility of future disability for a child rather than the child's present condition, as is required by the title XVI statute for children.

In paragraph (c), we define the terms "age-appropriate activities," "developmental milestones," "activities of daily living," "developmental domains," and "functional domains." These are terms that are used by professionals who deal with children who have impairments and that we find in evidence from such individuals. We will use these terms to describe the components of individualized functional assessments.

In paragraph (c)(1), we explain that the term "age-appropriate activities" is a comprehensive term that refers to the normal activities of a child of any age; i.e., what a child is expected to be able to do given his or her age. It may refer to any discrete behavior of an infant or young child (e.g., the age at which an infant can turn its head from side-to-side, or an older child is able to utter two-word sentences) or to any global behavior of an older child or adolescent (e.g., reading). In the evidence of record, a child's activities may be described in terms of the achievement of "developmental milestones," "activities of daily living," or other such terminology. Information about a child's activities creates a profile of how the child is functioning, i.e., what a child does, and thus what he or she is able to do. This makes possible a comparison between the child's profile and the activities that are age-appropriate for that child.

In paragraph (c)(2), we explain that the term "developmental milestones" refers to a child's expected principal developmental achievements at particular points in time. Ordinarily, failures to achieve developmental milestones are the most important indicators of impaired functioning in children from birth until the attainment of age 6, although they may be used to evaluate older children, especially school-age children.

In paragraph (c)(3), we explain that the term "activities of daily living" refers to those activities of children that involve continuity of purpose and action, and goal or task orientation; that is, the practical implementation of skills mastered at earlier ages. Ordinarily, activities of daily living are the most important indicators of functional limitations in children aged 6 to 18, although they may be used to evaluate younger children, especially preschool-age children.

In paragraph (c)(4), we explain that the terms "developmental domains" and "functional domains" refer to broad areas of development or functioning that can be identified in infancy and traced throughout a child's growth and maturation into adulthood. The terms describe a child's major spheres of activity physically, cognitively, communicatively, and socially/

emotionally. In these regulations, the term "developmental domains" is generally used when we discuss younger children, i.e., from birth to age 6; the term "functional domains" is generally used when we discuss older children and young adolescents, i.e., from age 6 to age 16. We also provide a cross-reference to § 416.924c, where we describe in detail the various domains as they pertain to the different age groups.

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

Paragraph (a) of this section explains how we consider age in childhood cases at each step of the childhood sequence of evaluation. Ordinarily, age is considered in determining whether a child has impairments that meet or equal a listing only when the listing we are using for comparison includes separate criteria for different ages. At the second and last steps of the sequence, however, age is integral to every determination, inasmuch as we must consider a child's abilities to perform age-appropriate activities. "Age" means chronological age, except in the cases of premature infants who are considered disabled under special rules for low birth weight, as we explain in a separate paragraph (c).

In paragraph (b), "Age categories," we define the three age categories we use as guidance for assessing age-appropriate activities: newborn and young infants (birth to attainment of age 1), older infants and toddlers (age 1 to attainment of age 3), and children (age 3 to attainment of age 18). We will not apply the age categories mechanically in borderline situations. The categories are the same as those in the childhood mental listings, and are based on the recognition that there are broad developmental and functional domains common to these age categories. We also describe four subdivisions of the age-3-to-18 category. As in the childhood mental listings, we recognize that impairment manifestations within the domains, and the evidence that will be needed to evaluate these manifestations, will vary for different age levels within the group. We have, therefore, provided the following more specific categories: preschool (age 3 to attainment of age 6), school-age (age 6 to attainment of age 12), young adolescent (age 12 to attainment of age 16), and older adolescent (age 16 to attainment of age 18).

In paragraph (c), "Evaluation of premature and low birth weight infants," our method of considering prematurity is the same as the standard generally followed in neonatology. For purposes of these rules, we define prematurity as birth at less than 37 weeks' gestation. Under our rules for functional equivalence in § 416.926a(d), infants who weigh less than 1200 grams at birth or who weigh at least 1200 grams but less than 2000 grams and are at least 4 weeks small for gestational age are found disabled. If an infant is not considered to have an impairment that is functionally equivalent to a listing in this manner under the new provisions in § 416.926a, we will evaluate the child using a corrected chronological age. The corrected chronological age is the age obtained by subtracting the number of weeks of prematurity from the child's chronological age. We will use the corrected chronological age until it is no longer a significant factor, which is generally about chronological age 2. We further explain that, when we evaluate growth impairments using standard neonatal growth charts, we will not compute a corrected age if the charts already include this computation.

In paragraph (d), "Impact of severe impairment(s) on younger children and older adolescents," we provide general guidance on considering the effects of age when determining the impact of impairments on development and functioning at the two age extremes of childhood. This guidance may also be used to infer the effects of age in the intervening years. We explain that our assessment of the impact of impairments on children's development and functioning will consider age in a manner similar to how we consider the impact of age in adults when we make determinations at the fifth step of the adult sequential evaluation process, except in the opposite way; that is, as a general, though not invariable, rule, age has the greatest significance the younger the child is and is a lesser factor as the child approaches adulthood. Inherent in this guidance is also the recognition, built in throughout the new rules, that the very youngest infants are difficult to test and exhibit a narrow range of medical findings and behaviors. As infants age, observations and testing become more informative and more precise.

Although adults of any age may be found disabled at the last step of the adult sequential evaluation process, we consider advancing age to have an increasingly adverse impact on an adult's ability to make an adjustment to other work, or to begin work for the first time. Thus, adults who are of advanced age (age 55 or older) or who are closely approaching retirement age (age 60 or older) may be found disabled with less severe impairments than younger adults. At the opposite end of the adult spectrum, our rules recognize that younger individuals (i.e., those age 18 to age 45) are better able to adapt to the workplace despite severe impairments.

Children, of course, are not easily compared with adults. Nevertheless, it is possible to make some generalizations about the effects of age in the youngest and the oldest children. In general, impairments that affect an infant's or young child's growth or development can have a more substantial impact on the child's overall functioning (the analog to an adult's ability to adapt to other work) than the same impairments would have on an older child. This is because children develop many of their skills sequentially, building upon skills they have already achieved. Furthermore, the acquisition of skills is not a simple straight-line process confined to single domains; there is a complex interdependence among the domains, so that interference in a child's acquisition of skills in one domain can have an effect upon the child's development in other domains as well. The younger the child, the more serious the total impact can be.

Conversely, by the age of adolescence, children have acquired and developed basic physical and mental functional abilities, skills and behaviors, such that impairments do not have the cumulative impact on functioning that they do in infants and young children. As children approach adulthood—that is, by about age 16—they have the same abilities to adapt as the youngest adults. They also exhibit functional abilities, skills, and behaviors that may be meaningfully compared with those of 18-year-olds.

We do not intend for this rule to be applied mechanically. We recognize that there will be cases in which impairments acquired by older children will have a greater impact than the same impairments in younger children. Our intent is to provide only general guidance, with the understanding that each case must be evaluated on its own merits.

Section 416.924c Functioning in Children

In this section, we describe the domains of development and functioning and certain behaviors in which we evaluate children when we do individualized functional assessments. We also provide age-appropriate examples for each domain and behavior. To describe a child's mental or physical functioning, we employ as a frame of reference the terminology and definitions in the listing of childhood

mental disorders in 112.00C of the Listing of Impairments in appendix 1 to subpart P of part 404.

The descriptors of functioning in the childhood mental listings also include developmental and functional domains and behaviors. These domains can also be appropriate to the evaluation of physical impairments. However, because the childhood listings are designed for the evaluation of mental disorders, they do not include descriptors of the range of functions necessary to address all physical and mental impairments in all the age categories needed for the more refined assessment of functioning in the individualized functional assessment. We have, therefore, added to the descriptors of the listings and modified some of them in this rule.

In this rule, we have divided the cognitive/communicative domain of the childhood mental listings into two separate domains (that is, cognition and communication) for children in all of the age categories in order to recognize the specific role that speech and language have in a child's development or functioning. We have also included the domain of personal/behavioral functioning in the age group of older infants and toddlers (whereas the childhood mental listings do not) in order to recognize the development of self-help skills and other activities appropriate to this age group. In addition, we have added the domain of motor development or functioning to the age groups ranging from age 3 to the attainment of age 16 in order to recognize the physical development or functioning of children in these age groups.

In paragraph (a), we identify the developmental and functional domains and behaviors that we will use in the individualized functional assessment. We explain that when a child's impairment(s) affects a particular domain or behavior, we will consider the extent of the child's limitations as well as how well the child can do age-appropriate activities despite his or her limitations. We further explain that we will consider how a child's impairment(s) in one domain affects the child in other domains, and whether any help or intervention the child needs in order to do any particular activity is appropriate to the child's age.

In paragraphs (b) through (g), we describe the functioning of children according to the domains or behaviors appropriate to the several age groups. For each group from birth to the attainment of age 16, we discuss the general kinds of activities that characterize each developmental or functional domain or behavior.

When we consider the functioning of older adolescents, from age 16 to the attainment of age 18, descriptive information about their activities of daily living will tell us something about how they are affected by their impairment(s). For this age group, those activities at school which give evidence of the individual's ability to function in a job setting, as well as the activities in any actual employment that the older adolescent may have are primary indications of functional capacity.

Section 416.924d Other Factors We Will Consider in the Individualized Functional Assessment

This section discusses some of the other factors we will consider when we do individualized functional assessments. Its provisions are based on 12.00E, F, G, and H of the adult mental listings and 112.00E and F of the childhood mental listings, as well as input from the experts who assisted us.

Both the adult and childhood mental listings explain that, in mental disorders, superficial appearances or single examinations may or may not accurately reflect an individual's ability to function in normal settings. Individuals with chronic mental impairments may have their lives structured in such a way as to minimize stress and reduce their overt signs and symptoms, yet be unable to tolerate the stresses of normal activities without worsening their signs or symptoms. Some may appear less impaired on a single examination than the longitudinal evidence may show. Similarly, structured settings, hospitalization, residential placement, and other sheltered environments may have the same effect of apparent improvement in an individual's condition when, in fact, the individual may or may not be able to function independently as well as he or she would appear to be able to within the sheltered setting. Both the adult and the childhood mental listings emphasize the necessity for careful evaluation of all of the evidence relevant to the individual's ability to function under normal circumstances.

The introductory paragraphs to the adult and childhood mental listings also provide guidance for evaluating the effects of medication and other treatment. They point out that adverse side effects of medication can themselves contribute to functional impairment. Treatment may also minimize the most obvious effects of a mental impairment, yet not result in a significant improvement in the individual's ability to function. On the other hand, treatment may actually improve an individual's condition. Again, the principle stressed in both listings is the importance of considering all of the relevant evidence and of making careful judgments on a case-by-case basis.

We believe that these principles, which we have used in adjudicating mental impairment cases since the adult mental listings were published in 1965, are generally applicable to the evaluation of childhood disability cases, irrespective of whether they involve mental impairments. We have, therefore, included them in new § 416.924d, with guidance specific to children. Paragraph (a) summarizes the kinds of factors we will consider, and subsequent paragraphs provide more detail than is in either of the sets of mental listings.

We provide in paragraph (b) that chronic illness resulting in frequent hospitalizations or outpatient care can itself be the basis for a finding of disability. Paragraph (c) explains that medication may improve a child's symptoms, signs, or laboratory findings but may itself be the cause of additional limitations. Medication may also lessen obvious symptoms and signs without actually improving the child's ability to function independently, appropriately, or effectively in an age-appropriate manner.

Paragraph (d) emphasizes that nearly all children live in some sort of structured setting or environment, such as a family or an institution, and are subject to adult supervision or interaction in the home, at school, and elsewhere.

In paragraph (e), "Adaptations," we extend our policies for considering the effects of medication and other treatment to the consideration of assistive devices, appliances, and technology, and to special support services or intervention. We explain that some adaptations can result in improvement by restoring adequate functioning (for example, eyeglasses); that some adaptations can effect some improvement, but cannot be said to restore adequate functioning; and that some adaptations may themselves impose limitations.

In paragraph (f), we discuss a child's potential need for therapy from more than one kind of health care professional in order for the child to maintain or improve functional status. We explain that when we determine whether the child is disabled, we will consider the effect of such multidisciplinary therapy on a child's development and ability to engage in age-appropriate activities; i.e., the extent

to which a frequent, ongoing regimen of therapy interferes with the child's age-appropriate functioning.

In paragraph (g), we explain that schools are important sources of information and that we will consider this information. We also explain, however, that the fact that a child is able to attend school does not in itself indicate that the child is not disabled. Similarly, even though we will consider the fact that a child is or is not placed in a special education setting when we assess the child's abilities, we will consider each child's individual circumstances and not draw any conclusions based on the mere fact of placement or lack of placement; indeed, some schools do not offer special education classes. As with all the other factors in this regulation, appearances may or may not reflect a child's actual abilities or limitations. However, evidence showing that a child is prevented from attending school on a regular basis because of a medical condition(s) may be a reliable indicator of impairment severity.

Paragraph (h) corresponds to the provisions in 12.00H of the adult mental listings. It is a reminder that, notwithstanding the discussions in paragraphs (b) through (g) about the possible negative or masking effects of a child's treatment or intervention, it is also possible that treatment or intervention can control, reduce, or eliminate functional limitations resulting from an impairment(s).

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

In this section, we provide a framework and examples for evaluating childhood disability claims at the last step of the childhood sequence. The regulation provides guidelines to assist the adjudicator in determining when a child's impairment(s) is of comparable severity to an impairment(s) that would disable an adult. The guidelines are intended to illustrate severity; they do not comprise all-inclusive, hard-and-fast rules for decisionmaking.

The guidelines in this section are based on the rules and principles already present in the new listings for mental disorders in childhood. The childhood mental listings provide rules for evaluating mental disorders in terms of domains of functioning and abnormalities of behavior, specified according to the different age categories. They also provide guidance for rating the severity of functional limitations at the listing level. Thus, children from birth to the attainment of age 3 are found to meet listing-level severity for mental disorders if they are functioning in one developmental area (e.g., motor development) at a level that is no more than one-half of their chronological age, or at no more than two-thirds of their chronological age in each of two developmental areas (e.g., cognitive/communicative and social function). Children from age 3 to the attainment of age 18 are found to meet listing-level severity if there is marked impairment of their functioning in two functional areas (e.g., social and personal/behavioral). The severity level, "marked," is defined in 112.00C of the listings in terms describing serious interference with the ability to function independently, appropriately, and effectively in an age-appropriate manner and on a sustained basis. "Marked" is said to fall between a moderate and an extreme level of impairment; the term also equates with a valid standardized test score that is two standard deviations below the norm.

Using the severity levels of the childhood mental disorder listings as a broad frame of reference, we have extrapolated for children of various ages those levels of impairment severity of both mental and physical impairments that would constitute "moderate" limitation of functioning; i.e., a severe impairment or combination of impairments that has more than a minimal effect on a child's ability to function in an age-appropriate manner, yet is less than "marked" in its effects. We then devised examples of impaired functioning at the different age levels that would not be at the listing level but that we would generally find disabling. The examples employ terminology and guidance both from the childhood mental listings and from §§ 416.924 through 416.924d, especially § 416.924c, to describe the impact of mental and physical impairments on children at the various ages.

Our approach to older adolescents, age 16 to the attainment of age 18, focuses on the critical transition that adolescents experience as they approach young adulthood. Children in this age category are closely approaching adulthood, and are much like 18- and 19-year-old adults in their physical and mental activities and capabilities. The notion of "comparable severity" to an adult, therefore, is more work-related in this age category than in the younger age categories. However, unlike the rules for evaluating adults, the guidance in this section provides that older adolescents must still be evaluated in terms of limitations and abilities in age-appropriate contexts.

Section 416.924e is organized as follows:

In paragraph (a), we provide a general introduction to the guidelines as a framework for deciding comparable severity. We emphasize to adjudicators that the guidelines are not rigid rules and that evaluation of disability in each child must be made on the basis of all relevant evidence in the child's case, using the principles in all of the childhood regulations.

In paragraph (b), we explain how we describe the functional impairments of children in the examples. We explain that the impairments of children from birth to the attainment of age 3 are generally described in terms of developmental delay, i.e., the fraction or percentage of the child's chronological age that represents his or her level of functioning in a mental or physical domain. Developmental information about these children is often available in the results of formal testing as well as the clinical reports and observations of the people who treat the children for their impairments.

The impairments of older children and young adolescents, from age 3 to the attainment of age 16, are generally described in terms of age-appropriate activities, functional abilities, or abnormal behaviors. Apart from testing of intelligence, aptitude, and academic achievement in school contexts, however, older children and young adolescents may undergo formal testing less often than children in the younger categories, who are in the early developmental years. Information about an older child or young adolescent's functioning may be obtained in descriptive terms concerning the child's activities of daily living. The functioning of older adolescents, age 16 to the attainment of age 18, is also more likely to be reported in descriptive terms, which tell us about the individual's physical and mental capacities as they are manifested in school, work, or worklike settings.

In paragraph (c), we provide guidance and examples for evaluating impairment severity for children from birth to the attainment of age 16.

In paragraph (d), we discuss older adolescents, age 16 to the attainment of age 18. We explain that these individuals, because they are closely approaching adulthood and have many of the same abilities, behaviors, and activities as young adults, can be evaluated in terms that are the same as, or similar to, those used for evaluating disability in adults. We then provide guidance for evaluating the mental or physical functioning of individuals in this age group, acknowledging that the guidelines, as for all the age groups, are

not to be applied in a rigid or mechanical manner, and that each case must be evaluated on its own merits, using the guidance of all of the regulations addressing childhood disability.

Section 416.926a Equivalence for Children

We are changing our policy for deciding whether a child has an impairment or combination of impairments that is equivalent in severity to a listed impairment. The changes add a new method of determining equivalence for children that is based on an assessment of the child's functioning and a comparison of this assessment with the functional consequences of impairments in the listings.

Background. Our previous rules for determining equivalence in childhood claims were contained in regulation § 416.926, which is still to be used in adult claims, and in Social Security Ruling (SSR) 83-19, entitled "Titles II and XVI: Finding Disability on the Basis of Medical Considerations Alone—The Listing of Impairments and Medical Equivalence." We rescinded SSR 83-19 on April 5, 1990.

The rules in § 416.926 and in our previous interpretive instructions called for a comparison of the child's medical "symptoms, signs, and laboratory findings" of an individual's impairment(s) with the symptoms, signs, and laboratory findings of impairments described in the Listing of Impairments in Appendix 1 of Subpart P of Part 404, from which comparison a judgment as to medical equivalence was to be made. Equivalence could be found in only three circumstances:

1. If the child had a single listed impairment, but one or more of the specified medical findings in the listing were absent, medical equivalence could be found if the person had other, related medical findings that were equal or greater in clinical significance to the absent listed findings.

2. If the child had a single impairment that was not listed, medical equivalence could be found if the impairment demonstrated medical findings that could be compared in severity with the findings associated with the most closely analogous listed impairment.

3. If the child had a combination of impairments, no one of which by itself met or equaled a listing, medical equivalence could be found by comparing the combined sets of symptoms, signs, and laboratory findings of all of the child's impairments and determining that they were medically equivalent in medical severity to that listed set to which the combined sets could be most closely related.

Two of our former equivalence procedures for children have been the focus of some criticism. The first was that our former policies prohibited findings of equivalence when children lacked listed findings and had no other related medical findings of equivalent significance; furthermore, we did not consider symptoms, no matter how severe, to be acceptable substitutes for absent listed findings. The second was that we did not permit a finding of equivalence based on an assessment of the child's overall functioning.

Basis of our policy. The new rule is based on three primary sources:

a. The Supreme Court decision in "Zebley", which addressed the use of our equivalence rules in adjudicating childhood cases in the absence of an individualized functional assessment;

b. An idea for a "screening" step for children that came out of our discussions with the experts who helped us in our formulation of the new childhood regulations; and

c. The Listing of Impairments itself, which contains examples of overall impairments of functioning, as exemplified by the paragraph "B" and "C" criteria of the adult mental listings and the paragraph "B" criteria of the childhood mental listings, and various other types of functional impairments.

1. *The Supreme Court decision.* In "Zebley", the Supreme Court found that the childhood disability policies for establishing equivalence "exclude[ ] claimants who have unlisted impairments, or combinations of impairments, that do not fulfill all the criteria for any one listed impairment." The Court also found that our policies for establishing equivalence did not give childhood claimants an opportunity for an adequate assessment of their functional limitations. The Court noted that the listings excluded, among other things, "any claimant whose impairment would not prevent any and all persons from doing any kind of work, but which actually precludes the particular claimant from working, given its actual effects on him—such as pain, consequences of medications, and other symptoms that vary greatly with the individual * * *."

Moreover, after the "Zebley" case was remanded to the U.S. District Court for the Eastern District of Pennsylvania, the lower court issued a stipulated order on May 5, 1990, providing an interim standard for childhood cases in compliance with "Zebley" pending publication of these regulations. The interim standard required the consideration of functioning in determinations of equivalence. Specifically, the new standard ordered by the district court required that for childhood cases involving single as well as multiple impairments, "no one of which in itself meets or equals a listing, such impairments *must* be considered in terms of their *combined* functional effects on the individual child to determine whether they are equivalent in severity to any listed impairment." (Emphases in original.) Thus, this new rule is based on the interim standard, which the district court ordered to comply with the "Zebley" decision.

2. *The screen.* The screening step suggested by individual experts would have been the first step of a disability evaluation process for children that would have also included a meets-or-equals-the-listings step. It was to be a separate list of specific medical conditions or kinds of medical conditions, specific functional limitations, and other effects of impairments. All would quickly identify children who were obviously disabled and who could immediately be found disabled with minimal development of the evidence.

Impairments could be suitable for inclusion on the list for several reasons. Conditions could be included because they were known to be fatal within a specified period of time; because they resulted in obviously disabling functional limitations (such as inability to walk, profound impairment of major organ function, or very severe cognitive impairment); or, though not so obviously disabling, because they had a profound effect on the child's life (for example, because they resulted in frequent or prolonged hospitalizations); or, in the case of certain episodic conditions, because the episodes were so frequent, despite treatment, that there was a profound impact on the child's day-to-day life.

In some cases, such as the expectation of death within a given period of time or profound decrease of function of a major organ, the nature of the impairment was the element that was critical to the determination of disability, and was essentially a purely medical determination. In the categories that relied on profound functional impairment, such as inability to walk, the nature of the impairment was, in a sense, less important to the finding of disability; what ultimately determined that a person was disabled were the consequences of the impairment, the inability to walk itself, more so than the medical reason why the child was functionally impaired. Once it was established that the child had a

medically determinable impairment or combination of impairments that caused the profound limitations, he or she had satisfied the legal requirement that disability be the result of a medically determinable impairment. The disability standard was satisfied by the functional limitation. The other impairments on the list could be viewed in a similar manner: the need for intensive treatment or frequent hospitalizations may ultimately be disabling because they interfere substantially with a child's normal functioning over time.

3. *The Listing of Impairments.* The listings contain impairments like those on the experts, proposed screen list. Several of the specific categories of medical disorders suggested by the experts for a tentative screen list, such as major organ transplants, in fact already include listed impairments. The listings also contain many impairments that are expected to result in death or that are disabling because of their functional consequences.

However, the listings are medically specific; that is, they link the disabling consequences of impairments to specific medical diagnoses or to specific body systems. They, therefore, could present an obstacle to comparing impairments that should be susceptible of comparison. For example, current listing 106.02D provides for a finding of disability for at least 1 year following kidney transplantation; the same finding could be made for other major organ transplants (e.g., heart, liver), or based on the fact that a person is on a list for such a transplant, even though the listings do not currently include these possibilities. We have removed this obstacle with these new rules and the adoption of the idea that the primary focus should be on the disabling consequences of an individual's conditions, as long as there is a direct, medically determinable cause for an individual's disability.

There are many specific functional impairments stated in the listings, such as deafness, inability to walk or marked impairment of ambulation (due to a variety of impairments, such as amputations, deformity, or other musculoskeletal disease: paralysis, and other neurological disease; and mental disorder), cognitive deficit, and specific diagnoses expected to result in death.

Moreover, the paragraph B and C criteria of the adult mental listings in 12.00 of part A of the listings (which can be applied to children), and the paragraph B criteria of the new childhood mental listings in 112.00 of part B of the listings illustrate that there is another, comprehensive way to look at the functional effects of impairments.

In several of the examples above, the impairments have impacts on specific functions or carry the expectation of death. The paragraph B and C criteria of the childhood and adult mental listings may be viewed as describing the impact of specific functional limitations on overall functioning in broad domains of activity, behavior, or ability.

For instance, the third paragraph B criterion for children age 3 to 18 describes marked impairment in personal/behavioral function as evidenced by marked restriction of age-appropriate activities of daily living; these activities are further described by more refined age breakdowns in 112.00C. Similarly, the first paragraph B criterion in the adult mental listings, activities of daily living, is defined in 12.00Cl in terms of adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for one's grooming and hygiene, using telephones and directories, and using a post office. It is self-evident that a person could have a physical impairment (or a combination of physical impairments or physical and mental impairments) that could cause the same limitations of the activities of daily living.

Indeed, both 12.00A and 112.00A provide that the paragraph B and C criteria—not the paragraph A criteria, which substantiate the existence of the particular mental disorders in the listings—set the standard for determining listing-level severity. Section 12.00A states: "The purpose of including the criteria in paragraphs B and C of the listings for mental disorders is to describe those functional limitations associated with mental disorders which are incompatible with the ability to work." Likewise, 112.00A provides: "The purpose of the paragraph B criteria is to describe impairment-related functional limitations which are applicable to children." In both sections, the functional restrictions must be the result of the mental disorder which is manifested by the criteria in paragraph A.

Hence, the mental listings demonstrate that it is not so much the cause of the functional impairment that establishes disability but the effect, the functional consequence itself, provided that the effect is the result of a medically determinable impairment or combination of impairments.

The new rule. The new regulation for children, § 416.926a, establishes several new principles in our rule for determining equivalence. The new rule provides a means by which children with any medically determinable impairments or any combination of impairments, can establish that they have impairments that are equivalent in severity to listed impairments. It carries the recognition that the listings do not include every possible medical condition or combination of conditions from which an individual might suffer by providing that the listings are a standard and a set of examples by which every possible condition or combination of conditions can be judged. It is predicated on the principle that the listings include examples of functioning that demonstrate a level of severity establishing inability to engage in gainful activity or that would, in a child, be comparable to this inability.

The rule provides that, if a child's impairment(s) does not medically equal any listing under our existing rules for equivalence, an assessment of his or her functional limitations will be made and compared with the disabling functional consequences of any impairment in any listing. The child's functional limitations need not be compared with an impairment that is medically "related" to his or her medical impairment(s); however, the functional limitations must arise from a medically determinable impairment or combination of impairments. The assessment of the individual's functional limitations will consider the impact of all of the individual's medically determinable impairments on his or her functioning and consider all relevant evidence, including the effects of the individual's symptoms, the side effects of medications, and all other relevant evidence we consider when we assess functioning.

This approach will readily identify disabled children like the screen proposed by the experts. However, the screen would have resulted in another circumscribed list of impairments in addition to the listings, albeit with many items that were not specific medical conditions, as in our listings. Although many of the experts thought that impairments on the screen list could have been evaluated more easily than impairments in the listings, we do not fully agree; for example, there is no distinction between the evidence we would have been required to gather using the screen list and the evidence that will be needed to apply the new equivalency rules in order to comply with the law.

For clarity, we are also providing a new paragraph (d) which gives examples of functional impairments that will equal the listings; several of the examples were derived from the screen list.

We have also retained our existing policies for determining medical equivalence based on medical findings, although we have revised the language of the new regulation to combine and clarify the rules. We believe that the *Zebley* decision does not preclude us from continuing to use our longstanding policies to permit determinations of equivalence. Rather, the court held that our policies did not go far enough.

Other changes. In addition to the foregoing revisions, new § 416.926a does not contain a paragraph that corresponds to § 416.926(b) of the adult rules, "Medical equivalence must be based on medical findings." Our intent is to remove any suggestion that the ultimate finding of equivalence must be based on objective medical evidence alone.

Because we did not copy the text of § 416.926(b) in the new regulation for children, the new regulation also does not contain a provision regarding the "medical opinion of one or more medical or psychological consultants designated by the Secretary," which has been the source of some confusion in the past. The sentence uses the terms we use to describe the physicians and psychologists who make determinations at our State agencies—medical and psychological consultants. It also refers to § 416.1016, the regulation that explains the qualifications of these individuals.

Medical and psychological consultants are adjudicators at the initial and reconsidered determination levels; as such, they do not express opinions about equivalence, but make findings that become part of the determination. Our policy is that medical and psychological consultant findings on equivalence become opinion evidence only in cases that rise to the administrative law judge hearing level and to the Appeals Council. However, the sentence in § 416.926(b) does not make this policy clear; therefore, it could be misunderstood.

For similar reasons, we have not retained the language of § 416.926(c) in § 416.926a(c), inasmuch as it also refers to medical and psychological consultants, but fails to mention the medical experts (formerly called medical advisors) employed by the Office of Hearings and Appeals to function as physicians designated by the Secretary. For clarity, and because of our changes in policy, paragraph (c) of the new regulation for children is similar to our provisions in § 416.946, regarding our policies on the responsibility for making residual functional capacity determinations. Section 416.926a(c) details our longstanding policy on adjudicator responsibility for equivalence determinations at each level of application and appeal. At the initial and reconsideration levels, the medical or psychological consultant is responsible for the finding of equivalence. At the disability hearing reconsideration level, the disability hearing officer or the Associate Commissioner for Disability (successor to the Director of the Office of Disability Hearings), or his or her delegate, is responsible. At the administrative law judge hearing level and the Appeals Council level, the administrative law judge and the Appeals Council are responsible.

Section 416.994a How We Will Decide Whether Your Disability Continues or Ends, Disabled Children

Because the rules for finding a child disabled are no longer based on a listings-only test, we have also revised our policies for finding that a child's disability continues or has ended, which were also based on a listings-only test. We have, therefore, provided a new regulation, § 416.994a, for the evaluation of continuing disability in childhood claims that is no longer based on a listings-only test. We have removed the former provisions in § 416.994(c) without replacement; § 416.994 now applies only to the evaluation of continuing disability in adults.

We have generally adopted the provisions of the adult rules for determining continuing disability as a model for the new childhood rule, inasmuch as our new childhood disability process is now comparable to the adult process. However, we have simplified the language and organization of these rules as compared to the adult rules, although we have retained all of the language from the adult rules, and former childhood rules, that mirrors the language of the law. Except as explained below, any changes in language are not intended to change our policies. We have, of course, also taken into account the terminology and sequence of the new rules for evaluating childhood disability in §§ 416.924 through 416.924e.

An example of how we simplified the language of the regulation without changing its meaning is presented in the third step of the new childhood sequence. Under the law, we must show that an individual's impairment(s) has medically improved and that the medical improvement is related to the ability to work. (As we explain later in this preamble, we use the term "ability to work" because it is provided in the Act; however, we have defined it in these rules in terms appropriate to children.) If we cannot demonstrate improvement, or that improvement is related to the ability to work, we will ordinarily find that the person's disability continues. However, there are exceptions that permit us to find that an individual's disability has ceased or to continue evaluating the individual's case to determine if the individual is currently disabled.

In paragraph (b)(3) of the new regulation, we make a statement to this effect, explaining how the exceptions to medical improvement related to the ability to work impact on the outcome of the case:

(3) *If there has been medical improvement, is it related to the ability to work?* If there has been medical improvement in your impairment(s), we will determine whether your medical improvement is related to the ability to work, as defined for children in (d). If it is, we will proceed to the next step. If the medical improvement of your impairment(s) is not related to the ability to work, we will find that your disability continues, unless one of the exceptions to medical improvement described in (f) or (g) applies.

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

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

Sections 416.994(b)(5)(iv), and (v) of the adult rules contain the same provisions, but in a different presentation:

(iv) If there has been medical improvement, we must determine whether it is related to your ability to do work in accordance with paragraphs (b)(1)(i) through (b)(1)(iv) of this section; i.e., whether or not there has been an increase in the residual functional capacity based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is not related to your ability to work, see step (v). If medical improvement is related to your ability to do work, see step (vi).

(v) If we found at step (iii) that there has been no medical improvement or if we found at step (iv) that the medical improvement is not related to your ability to work, we consider whether any of the exceptions in paragraphs (b)(3) and (b)(4) of this section apply. If none of them apply, your disability will be found to continue. If one of the first group of exceptions to medical improvement applies, see step (vi). If an exception from the second group of exceptions to medical improvement applies, your disability will be found to have ended. The second group of exceptions may be considered at any point in the process.

The statement that we may consider exceptions in the second group of exceptions at any point in our process is now in paragraph (g), the section that

describes the second group of exceptions.

We have also updated the rules with respect to children to reflect changes that have taken place since we first published the medical improvement standard. For example, we deleted all references (from the sequence and elsewhere) to substantial gainful activity. Under section 1619 of the Act, we do not find that any eligible individual's disability has ended because he or she is engaging in substantial gainful activity. We no longer apply the concepts of "trial work periods" or the "reentitlement period" (i.e., the extended period of eligibility) in SSI claims. Instead, we determine whether the individual continues to have a "disabling impairment," as defined in § 416.911. If the individual is working despite having a disabling impairment, cash benefits and Medicaid benefits may continue. If the individual does not continue to have a disabling impairment, we will find that his or her disability has ended. In either event, the fact that the claimant is working is not pertinent.

We have also made a number of minor changes to the language we adopted from the adult rules and our former childhood rules. These changes are intended to have no effect on the meaning of the rules. For example, the adult rules sometimes use interchangeably the terms "determination" and "decision," signifying the final adjudication of a case. In fact, § 416.1401 of our regulations provides that the terms have separate meanings. A "decision" means the decision made by an administrative law judge or the Appeals Council, whereas a "determination" means the initial determination or reconsidered determination made at a State agency, the Federal Disability Determination Services, or by a disability hearing officer. We have, therefore, clarified the language of the regulation by using the phrase "determination or decision" wherever appropriate.

We have also eliminated language that could be viewed as redundant. For instance, we define the term "medical improvement" only once in the new regulation. We also do not repeat provisions of the initial determination process described in §§ 416.924 through 416.924e, which we use when we must determine whether a child is currently disabled. Instead, we provide cross-references to the appropriate regulations.

We have also chosen not to provide lengthy examples like the ones in the adult rules, because we believe they no longer are needed. We put examples in the initial medical improvement regulations because, when we first published the rules in 1985, the concept of medical improvement was new and we wanted to be sure that the rules would be understood and applied consistently.

We explain other changes in the following summary of the new regulation.

In paragraph (a), we provide an overview of the regulation. We indicate that in our continuing disability review sequence for children, the first step is whether the child has an impairment or combination of impairments that meets or equals the severity of any current listing. If not, we determine whether there has been any medical improvement related to the ability to work and, if so, whether the child is currently disabled. We explain that we derived the phrase "related to the ability to work" from the law, but that we have defined the phrase in paragraph (d) in terms that are meaningful to children. Paragraph (a)(2), regarding evidence and the basis for our decision, contains the provisions that were formerly at § 416.994(c)(1)(iv). We retained this paragraph intact because it reflects § 1614(a)(4) of the Act.

In paragraph (b), we describe the sequence of evaluation for continuing disability reviews;

1. At the first step, we explain that we will first determine whether the child has an impairment that meets a current listing, or an impairment or combination of impairments that is equivalent in severity to a current listing. If the child does, we will find that he or she continues to be disabled.

2. If a child does not have an impairment that meets or equals a current listing, we continue in the sequence and determine whether there has been medical improvement in the child's impairment(s). We do not define the term "medical improvement" in this section, but instead provide a cross-reference to the definition, in paragraph (c).

If there has not been medical improvement, we generally will find that the child's disability continues, unless one of the exceptions applies. The section explains that any of the first group of exceptions will cause us to continue to the fourth step in the sequence, while exceptions in the second group may result in a finding that disability has ended. With regard to the provisions in the sequence addressing the second group of exceptions, we have made a minor technical correction. We changed the language in the description of the sequence from "will," in former § 416.994(c)(5)(iv) to "may" in this subparagraph and in subparagraph (b)(3) of the new regulation. The word "will" in the former provision was inconsistent with the later provisions that describe the second group of exceptions in former § 416.994(c)(4), which we retained in new § 416.994a(g); the provisions describing the second group of exceptions state that we "may" find disability to have ended if one of the second group of exceptions applies. Therefore, the change only corrects an inadvertent error and does not change our policies.

3. If there has been medical improvement, we continue in the sequence and determine whether the child's medical improvement is "related to the ability to work." Again, instead of defining the term "related to the ability to work" within this section, we provide a reference to the definition in paragraph (d).

If medical improvement is not related to the ability to work, we generally will find that the child's disability continues, unless one of the exceptions applies. The regulation explains that exceptions in the first group of exceptions will cause us to continue in the sequence, while exceptions in the second group may result in a finding that disability has ended.

4. If medical improvement is related to the ability to work, or one of the first group of exceptions applies, we go on to determine whether the child's impairment(s) is currently severe. If the child no longer has any severe impairment(s), as defined in § 416.924(d), we will find that disability has ended. If the child's impairment(s) is severe, we proceed to the last step of the continuing disability sequence.

5. In the last step of the continuing disability sequence, we do an individualized functional assessment based on all of the relevant evidence in the case record and determine whether the child is currently disabled under the rules and guidelines of §§ 416.924 through 416.924e. If the child is currently disabled, eligibility continues. If the child is not currently disabled, eligibility ends.

In paragraph (c), we define medical improvement. We retain our definition of the term medical improvement as any decrease in the medical severity of the impairment(s) which was present at the time of the most recent favorable decision. A decrease in medical severity means that there has been improvement in the symptoms, signs, or laboratory findings associated with the child's impairment(s).

In (c)(1) we explain what we mean by the most recent favorable decision.

In (c)(2), we define the terms "symptoms," "signs," and "laboratory findings" by cross-reference to § 416.928. However, we also clarify our intent by stating that, for children, our definitions of the terms "symptoms," "signs," and "laboratory findings" may include the child's physical and mental functioning.

As the new childhood rules make clear, the significance of functioning in children is often critical to an understanding of their medical conditions. Indeed, in the case of infants who meet or equal listing 112.12, for example, and in many other cases of young children, evidence of functioning can serve the dual purpose of establishing the existence of a medically determinable impairment *and* of establishing disabling severity. We believe, as did the experts, that in such cases, evidence of a child's functioning can satisfy the definition of signs as "anatomical, physiological, or psychological abnormalities which can be observed apart from [symptoms]" and can be shown by medically acceptable clinical diagnostic techniques or by medically demonstrable phenomena which indicate specific abnormalities of behavior, affect, thought, memory, orientation and contact with reality. Since our definition of "laboratory findings" includes standardized tests, such as psychological tests, this definition can also include a child's functioning, as measured by an appropriate instrument.

In paragraph (c)(3), we retain the provision from the prior regulation that we will not consider temporary remissions in impairments that are subject to such remissions to be evidence of medical improvement.

In paragraph (d), we define the term "medical improvement related to the ability to work" in terms appropriate to children. Under the law (if no exception applies), we can find an individual to be no longer eligible for disability benefits only if there has been medical improvement in the individual's impairment(s) "other than medical improvement which is not related to the individual's ability to work." Instead of employing the Act's double negative, we rephrased the quoted requirement in positive terms of medical improvement that is related to the ability to work; that is, when there has been an increase in the child's ability to function independently, appropriately, and effectively in an age-appropriate manner. The section then explains that medical improvement is not related to the ability to work when there has been no such increase.

In (d)(1) and (d)(2), we provide detailed rules for determining whether medical improvement is related to the ability to work. In (d)(1)(i), we provide that, if a child was found to have an impairment or combination of impairments that met or equaled a current listing at the time of the most recent favorable decision and no longer has such an impairment or combination of impairments, we will find that medical improvement is related to the ability to work. Subparagraph (d)(1)(ii) is a provision for children for whom our most recent favorable decision was based on a finding that the child met or equaled a listing that is no longer in the listings or that has been revised. We explain that in such cases we will determine whether the child continues to meet or equal the prior listing. If so, we will find that disability continues; if not, we will find that there is medical improvement related to the ability to work and proceed to assess current disability.

In (d)(2), we provide that, if our most recent favorable decision was based on an individualized functional assessment, we will do a new individualized functional assessment based on the impairments that were present at the time of the most recent favorable decision; however, we will consider functions appropriate to the child's current age. We will use this assessment to determine whether there has been an increase in the child's ability to function in an age-appropriate manner comparing our current assessment with the assessment we made at the time of the most recent favorable determination or decision.

In subparagraph (d)(2)(ii), we have adopted provisions from the adult rules on prior residual functional capacity assessments. We provide that we will not substitute current judgment for our prior judgment by reassessing a child's functioning for the time covered by the most recent favorable determination or decision. However, there will be cases in which an individualized functional assessment formed the basis for the most recent favorable decision, yet is missing from the case file. In such cases, we will reconstruct the assessment. As in the adult rules, we will do this by assuming the maximum functional abilities consistent with a decision of allowance or continuance at the time of the most recent favorable decision; this is the most advantageous finding for the claimant when we determine whether there has been medical improvement related to the ability to work.

A determination that there has been medical improvement related to a child's ability to work does not mean that we will find the child no longer disabled. We must also show that the child is not currently disabled using rules governing the last step of the childhood sequential evaluation process for initial claims in §§ 416.924 through 416.924e.

Paragraph (e), "Prior file cannot be located," is the same provision that was in the former childhood rule at § 416.994(c)(2)(iii), revised to conform to the new rules for determining disability in § 416.924. The same provision also appears in the adult regulation. We have also corrected a misprint; the reference to "§ 416.988" should be to "§ 416.1488."

In paragraph (f), "First group of exceptions to medical improvement," we have revised the language to conform to the new childhood rules. Our revisions are modeled after the language in the adult rules, using appropriate terminology for children as necessary.

In paragraphs (f)(1), (f)(2), and (f)(3), the first three exceptions in the first group, we made minor revisions to the prior language to tailor it specifically for children. As explained above, we did not provide case examples to correspond to the adult examples.

We have updated paragraph (f)(3)(i)(B), the explanation (formerly in § 416.994(c)(3)(ii)(B)(*2*)) of the second procedure by which we will inform the public that there are new and improved diagnostic techniques we will consider when we apply the exception, by deleting text from the prior section that is no longer applicable. The former provision stated that we would publish in the Notices section of the **Federal Register** a cumulative list since 1970 of the new or improved diagnostic techniques or evaluations we would consider, as well as the month and year in which they became available. It also stated that we would not process any cases under the exception until we had published such a cumulative list.

We published the first cumulative list in the **Federal Register** in May, 1986 (51 FR 19413, May 29, 1986), and a second notice updating the list in May, 1990 (55 FR 19357, May 9, 1990). We have therefore revised the paragraph to delete the statements that indicate that we have not yet published any such lists.

In (f)(4), we made minor language revisions for clarity and we did not include case examples. Otherwise, the provisions are identical to the adult rules.

For reasons we have already explained, we did not include a fifth exception for children who engage in substantial gainful activity.

The language in paragraph (g), the second group of exceptions to medical improvement, is in the main unchanged. As we explained above in our example of how we simplified the language of paragraph (b), we have also moved the statement that the second group of exceptions may be applied at any point in the review process from the section detailing the sequence of evaluation into this paragraph.

In paragraph (g)(2), the second exception of the second group of exceptions, we have corrected a typographical error that was in the prior rules; we are making the same correction to the adult rules in § 416.994(b)(4)(ii). The reference to the good cause provisions of "Section 416.911" should refer to "Section 416.1411." We are also correcting an oversight in the prior childhood provision and the corresponding adult provision. We have rules for establishing good cause for failure to attend a consultative examination, and a discussion of the consequences of such failure, in § 416.918. We have, therefore, added a reference to this regulation in the childhood rule. These are longstanding policies; the revisions here are corrections, not changes.

In paragraph (h), "The month in which we will find you no longer disabled," we have deleted all references to findings of ending dates of disability following the completion of a trial work period or the reentitlement period, inasmuch as neither applies to individuals eligible for SSI. Therefore, we did not include a provision in the childhood rule to correspond to the fourth provision in the adult rules at § 416.994(b)(6)(i)(D), also in our prior childhood rules, which addresses ending disability following the completion of a trial work period. Likewise, we omitted the entire paragraph now in the adult rules at § 416.994(b)(6)(ii), also formerly in the childhood rules, regarding the setting of an ending date for disability in the month before the termination month; this is a reference to the rules on the reentitlement period. Because we no longer have a paragraph corresponding to § 416.994(b)(6)(ii), there was no need to distinguish two separate sections under paragraph (g) in the childhood rule; therefore, we have omitted the opening statement that the list of dates on which disability may end is only for purposes of § 416.1331, the rule which establishes that benefits can be paid for the month in which disability ends and the two following months.

In (h)(3), the provision regarding full-time work, we have added the phrase "or begin" after the word "to" in the clause "you return to work * * *." The provision (without the additional language) appeared in our former childhood rules; we retained it here because there might be rare instances in which it would apply to adolescents. For conformity, we also use the language now in the adult rule in § 416.994(b)(6)(i)(C), which is slightly different from the language of the childhood rule in former § 416.994(c)(6)(i)(C); there was no substantive difference in their meanings.

In paragraph (i), "Before we stop your benefits," we adopted the language of the adult rules.

The new childhood regulation does not contain a provision that would correspond to the provisions of former § 416.994(d), "Persons who were found disabled under a State plan," now redesignated as § 416.994(c) of the adult rules. The references to childhood claims in the former rules under § 416.994 were in error; in fact, there were no children who were found disabled under State plans and, therefore, no children were converted to SSI under the special rules for State conversions.

Explanation of Changes to Other Regulations

Section 416.901 Scope of Subpart

We revised paragraph (d) to indicate that it now applies only to adults. We added a new paragraph (e) that refers to the regulations for children, and redesignated all of the subsequent paragraphs.

Section 416.905 Basic Definition of Disability for Adults

We revised the section heading of this regulation to indicate that it provides the definition of disability for adults. We also added a cross-reference to § 416.920, the regulation that provides the adult sequential evaluation process, at the end of the last sentence.

Section 416.906 Basic Definition of Disability for Children

We revised the section heading of this regulation to use language in conformance with the section heading of § 416.905 and to delete the words "under 18," since we now provide a definition for the term "child" in § 416.901. We also added a sentence to refer to the new regulations for evaluating childhood disability.

Section 416.913 Medical Evidence of Your Impairment

We have added a new paragraph (a)(6) to this section to indicate that acceptable medical evidence includes the report of an interdisciplinary team that contains the evaluation and signature of an acceptable medical source. The language of the new provision is based on language in the third paragraph of 112.00D of the new listings for mental disorders in children which we published on December 12, 1990 (see 55 FR 51232). New paragraph 416.913(a)(6) is applicable to multidisciplinary evidence for any physical or mental impairments.

We have also added a new paragraph (c)(3) to this section, to define medical assessments in terms meaningful to childhood cases. We have also expanded the list of other sources of information in paragraph (e) to include more sources, such as parents and schools, that are relevant to children.

Section 416.916 If You Fail to Submit Medical and Other Evidence

We have revised the first sentence of § 416.916 to incorporate our current policies that the person acting on a child's behalf must also cooperate with us by providing evidence. We also clarify that cooperation means that the person must furnish evidence or help us to obtain or identify available medical or other evidence.

Section 416.920 Evaluation of Disability of Adults, in General; Section 416.921 What We Mean by a Not Severe Impairment(s) in an Adult

We revised the heading of § 416.920, to indicate that the sequential evaluation process in this regulation is only applicable to adults. We also revised the heading of § 416.921 to indicate that the definition of a "not severe impairment" in this regulation is only to be applied to adults.

Section 416.923 Multiple Impairments

We are adding a cross-reference to § 416.924 at the end of § 416.923 to indicate that the regulation is applicable to both adults and children.

Section 416.926 Medical Equivalence for Adults

We revised the heading of this section to indicate that it is to be used only in cases of adults.

Section 416.994 How We Will Decide Whether Your Disability Continues or Ends, Disabled Adults

We have made several nonsubstantive revisions to conform this regulation to the new childhood rules in § 416.994a. We changed the heading of this section to indicate that it is applicable only to adults. Because we removed the former childhood

paragraph (c), we have redesignated paragraph (d) as paragraph (c), and have made appropriate changes to the cross-references within that paragraph; in addition, we have removed the references to paragraph (a), which were erroneously in the paragraph. We have also revised paragraph (a) for the same reasons. As in the new childhood regulation, we are also changing the reference to "Section 416.911" in the second sentence of § 416.994(b)(4)(ii) to "Section 416.1411" to correct a typographical error.

Regulatory Procedures

We are publishing these new childhood disability rules as final rules with a request for comments instead of as proposed rules. Even though not required by statute, in all Social Security programs, as a matter of policy, we generally follow the Administrative Procedure Act (APA) notice of proposed rulemaking and public comment procedures specified in 5 U.S.C. 553 in the development of our regulations. The APA provides exceptions to its notice and comment procedures when an agency finds that there is good cause for dispensing with such procedures on the basis that they are impracticable, unnecessary, or contrary to the public interest. After due consideration, we have determined that, under 5 U.S.C. 553(b)(B), good cause exists for waiver of notice of proposed rulemaking on this regulation because such procedures are impracticable and contrary to the public interest.

The Supreme Court in its decision in "Zebley" determined that our regulations governing the evaluation of children's claims for disability under the Supplemental Security Income program could no longer be used to deny benefits. There is, thus, no binding regulatory standard in existence governing such evaluations, and hundreds of thousands of children who have had their claims adjudicated under the invalidated regulations or who have filed for benefits recently are waiting for final decisions. Current claims are being adjudicated under an interim standard, but that standard does not have the same binding effect as a regulatory standard and cases denied under the interim standard will have to be readjudicated under the new regulatory standard. Because there is no final regulation, these many thousands of children cannot obtain a final decision on their claims for benefits. Under these circumstances, the due and timely execution of the function of the Social Security Administration to decide the claims of these children and its duty to decide the claims fairly and in a timely manner would be seriously impeded by the notice of proposed rulemaking process. We believe it is essential to the public interest that the Supreme Court's decision in "Zebley" be implemented timely with finality, so that claims will be finally disposed of and claimants will know whether their claims are being allowed or whether they should seek further review. Indeed, the effective processing of children's SSI claims by the Social Security Administration requires that finality attach to the determination of their claims as soon as possible. The only way to ensure such timeliness, effectiveness and finality is to decide these claims now, under a final regulation, rather than incur the delay that the notice of proposed rulemaking process would entail before these claims could be decided with finality. For these reasons we find the notice of proposed rulemaking process impracticable and contrary to the public interest in this instance.

Some of the changes are merely technical and do not represent discretionary policy. They do such things as provide cross-references, correct erroneous citations, and change the headings of some provisions to indicate whether they apply to children or adults. These changes are so minor that we find that public notice and prior comment are unnecessary.

Executive Order 12291

Regulatory Impact Analysis

A. *Introduction.* The Secretary has determined that these regulations require a Regulatory Impact Analysis under Executive Order 12291 because they will result in a major increase in costs for the Federal government. Accordingly, the Department has prepared this Regulatory Impact Analysis to identify the cost impact and the potential benefits to society of these changes, and to inform the public of the considerations supporting these proposed revisions in accordance with Executive Order 12291.

Executive Order 12291 requires that a Regulatory Impact Analysis be performed on any major rule, i.e., a rule that is likely to result in—

• An annual effect on the economy of $100 million or more;

• A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or

• Significant adverse effects on competition, employment, investment, productivity, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

B. *Nature of the program.* Payments to certain disabled and blind individuals are provided under title XVI of the Act, the SSI program. An individual is considered disabled if he or she is "* * * unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment * * *, (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity)."

The Supreme Court, in the "Zebley" decision, decided that SSA's regulations implementing the law for evaluating disability in children did not adequately reflect Congressional intent. Implementation of the Supreme Court's decision requires us to revise the rules to provide an individualized functional assessment when evaluating disability in children for purposes of eligibility for SSI payments. We discuss the method used to revise the rules, including the solicitation and consideration of comments and suggestions from child development and childhood disability experts, and others, earlier in the section of this preamble entitled "Supplementary Information."

C. *Potential Benefits.* We expect that the new guidelines for determining disability in children will result in increases in the number of claims filed and allowed for children under the SSI program. This is because we have added a step to the disability evaluation process for children that permits findings of disability in children who do not have impairments that meet or equal a listing in appendix 1 of subpart P of part 404 of the regulations. For the same reason, we expect fewer terminations of payments of children already receiving SSI payments when their cases are periodically reviewed for continuing disability. Since, in many States, entitlement to SSI results in entitlement to Medicaid under title XIX of the Act, we also expect an increase in the number of children eligible for Medicaid.

D. *Projected Costs ($ in millions).* We have prepared both low and high estimates of the number of people affected, the amount of increased administrative costs and the amount of increased benefit payments. These estimates do not include administrative or program benefit costs for members of the "Zebley" class. Our estimates of the population of children who would be eligible are based on the National Health Interview Survey (NHIS), an annual survey conducted by the Bureau of the Census for the National Center for Health Statistics. The low and high estimates were developed by varying

the income assumptions for this population. Thus, the following two estimates represent the parameters of the expected increases in applications, allowances, and determinations of continuing entitlement.

5-YEAR PROJECTED EXPENDITURES

[Dollars in millions]

	FY'91	FY'92	FY'93	FY'94	FY'95	5-Year total
Low Estimate						
Federal SSI benefits	$65	$228	$334	$441	$533	$1,611
Federal Medicaid benefits	$25	$90	$140	$185	$235	$675
Total Federal benefits	$90	$318	$484	$626	$768	$2,286
Increased Federal administrative costs	$50	$55	$35	$37	$37	$214
Increased SSI applications (thousands) [1]	51	51	23	23	20	168
Increased SSI awards (thousands):						
New filers	17.9	17.9	7.9	7.9	7.5	59
Current filers	20	20	20	20	20	100
Total	37.9	37.9	27.9	27.9	27.5	159
High estimate						
Federal SSI benefits	$90	$328	$482	$603	$719	$2,222
Federal Medicaid benefits	$35	$125	$195	$255	$315	$925
Total Federal benefits	$125	$453	$677	$858	$1,034	$3,147
Increased Federal administrative costs	$89	$96	$57	$60	$61	$363
Increased SSI applications (thousands) [1]	98	98	44	44	42	326
Increased SSI awards (thousands):						
New filers	34.4	34.4	15.3	15.3	14.5	114
Current filers	20	20	20	20	20	100
Total	54.4	54.4	35.3	35.3	34.5	214

[1] A small percentage of disabled children have been found disabled based on assessment of their functioning, pursuant to the interim standard we have been using as a result of the district court order in "Zebley". However, the vast majority of eligible children now on the rolls were found disabled under our prior regulatory standards.

E. *Alternative Approaches*. Section 3(d)(4) of Executive Order 12291 provides that a Regulatory Impact Analysis shall provide a "description of alternative approaches that could substantially achieve the same regulatory goal at lower cost, together with an analysis of this potential benefit and costs and a brief explanation of the legal reasons why such alternatives, if proposed, could not be adopted." Described here are various alternative approaches that we considered in the course of developing the new rule.

In the final analysis, we concluded that we could not have achieved the same regulatory goal (i.e., fully complying with the principles enunciated in the Supreme Court's decision in "Zebley") at lower cost. We believe that the regulation as drafted is necessary to comply completely with the Supreme Court's "Zebley" decision and that the regulation is consistent with and is a reasonable interpretation of the Supreme Court's action in that case. The regulation is structured so as to provide complete and coherent rules for evaluating the disabilities of children under the Court's decision. For that reason, we have included some items not specifically mentioned by the Supreme Court, but which are a part of an integrated, rational and complete set of rules for the guidance of the public and the adjudication of children's claims. As it turns out, providing a whole set of rules for evaluating the disabilities of children as is done in this regulation is the least costly way of implementing "Zebley". As explained below, all the reasonable alternatives we considered would be more costly than the approach we have taken in this regulation. Moreover, we determined that any alternatives that would perhaps be less costly than the approach taken might run the risk of not complying fully with the Supreme Court's "Zebley" decision. A discussion of the alternatives we considered is offered to provide better insight into the decisionmaking process that led to the development of the new rule.

1. *Incorporating a Screen*—We considered incorporating a screen into the regulations; i.e., including as the first step of the childhood disability evaluation process a process in which children who are manifestly disabled could be identified quickly. As explained in the section of this preamble entitled "Supplementary Information," the screen would have been a list of specific impairments, or effects of impairments, that would result in an immediate finding of disability.

We decided not to include a screening list in these rules for several reasons, discussed at length in the preamble discussion of our reasons for revising our equivalence policy. In short, we decided that our revision of the equivalence policy was the better option because it includes the concepts of the screen, but in a more general rule. The screen list would have been only another circumscribed listing, similar to appendix 1. Therefore, we decided that the option we selected provides a greater net benefit to society.

Cost Considerations. We believe that the selected option is more administratively cost-effective than the screen, inasmuch as it permits our adjudicators to quickly and efficiently identify the most obviously disabled children. The screen list also would have been administratively cost-effective, but would have applied to

fewer cases. However, it still would result in higher overall administrative costs than the final rules since fewer cases would be decided under the screen than under the equivalence policy, necessitating more decisions after the individualized functional assessment. As we explain in the preamble, the documentation and adjudicative efforts would be the same under either approach.

As to program costs, the screen approach (like the functional equals step) was simply intended to identify the most seriously impaired children earlier in the adjudicative sequence. Thus, neither the proposed screen approach nor the functional equals approach, which we adopted, would affect program costs since both would allow children who would be found eligible later in the sequence.

2. *Including Risk Factors*—At the suggestion of individual experts, we also considered developing rules that would establish disability for children who are not currently disabled, based on a prediction that they might become disabled in the future because of their particular life circumstances. This approach would have been based on the premise that a combination of "risk" factors for a child with a medically determinable severe impairment(s) could affect the child's future development and that intervention now, through the assistance of SSI and the Medicaid entitlement that comes to SSI beneficiaries, could help to ensure that the child would not become disabled or that the child would have the best possible chance to maximize his or her abilities.

Risk factors include such things as familial/environmental risks (for example, very young parents), health-related risks (for example, lack of proper treatment and poor parental supervision), and biological risks (for example, the child's mother had a previous neonatal death).

In an attempt to draft such a rule, we tried to incorporate risk factors as an analogous step to the fifth step of the adult evaluation sequence. At that step, adults who have impairments that are not in and of themselves disabling (i.e., impairments that do not meet or equal the listings) can be found disabled because of the functional impact of non-medical factors (i.e., their age, education, and work experience). These vocational factors can have an effect on an adult's current ability to make an adjustment to other work, or to begin work for the first time and, hence, can contribute to a finding that the individual is disabled.

However, when we examined the rule we had drafted, we realized that it was not analogous to the adult rules. When we find an adult disabled based on consideration of his or her residual functional capacity and vocational factors, the adult is currently disabled, whereas a rule incorporating risk factors for children results only in a prediction of the possibility of future disability, not a finding of current disability.

Nonetheless, the rules we have established do not fail to consider risk factors on a child's current functioning. In the case of biological risk factors, the new rules provide several means for evaluating those children who are already affected by demonstrable biological problems (such as low birth weight, poor tone, and respiratory distress) in the new special rules for premature infants, the functional equivalence step for those children who do not already meet or equal listed impairment(s) solely for medical reasons, and the individualized functional assessment, all of which will require evaluation of the individual child's actual status. To count such factors again, however, in the same manner as age, education, or work experience in adults, would be a double weighting of the same factors. The other kinds of risk factors may also have an observable, current impact on a child and would, to that extent, also be considered when we assess the child's actual functioning.

We believe that any other consideration of risk factors would go beyond our authority due to the statutory requirement that a child "suffer[ ] from" an impairment of "comparable severity" to that of an adult. Predicting future disability based on risks goes beyond comparability to the adult rules. Furthermore, it is not reliably predictive, provides no basis for future comparison for determining continuing disability, and might require us to engage in intrusive investigative practices and to make value judgments that are far beyond our purview.

Cost Considerations. The inclusion of risk factors would have increased both program and administrative costs. Administratively, it would have resulted in additional development and investigatory procedures, as well as additional staff time justifying decisions. Because it would have granted benefits to children who are not currently disabled and who might not become disabled, it would have resulted in increased program costs; it would likely have increased program costs on continuing disability review as well. We are unable to estimate the extent of the increased costs.

3. *Limiting the Scope of the Regulations to Individualized Functional Assessment*—

• *Comparable Severity*—We considered limiting the scope of the regulations by simply adding a step after the meets/equals step in which adjudicators would determine, based on an individualized functional assessment, whether the child's impairment(s) is comparable in severity to one that would prevent an adult from engaging in substantial gainful activity. Under this alternative, we would not have developed the not severe step, the functional equivalence process, and the revised continuing disability review procedures. We did not adopt this alternative because it would not have achieved the same regulatory goal as these final rules: to fully and fairly implement the "Zebley" decision and comply with the law by providing a process for determining whether a child's impairment(s) is of comparable severity to an impairment that would disable an adult. We found, in reviewing the disability determination process for children and comparing it to the adult process, that simply adding a step that instructed adjudicators to assess a child's functioning and decide comparable severity would not provide a sound adjudicative process for deciding children's claims. Therefore, substantial legal support exists for not adopting this alternative.

Cost Considerations. With regard to initial cases, this alternative would not have changed the ultimate decision for any child. In other words, a child applicant, who is allowed at the functional equals step or denied at the not severe step would receive the same decision, only later in the sequence (i.e., after the individual functional assessment). However, it would have resulted in a further increase in administrative funds needed to process initial cases because it would have required that we subject every child who does not meet or medically equal a listing, including the most extremely impaired and the most minimally impaired children, to an individualized functional assessment. With regard to cessation cases, the inclusion of the revised medical improvement procedures allows the agency to resume conducting continuing disability reviews for children, which it has not been doing since the end of February 1990. As a result, the continuing disability review rules increase administrative costs. However, these administrative costs are more than offset by program savings

that would be lost if these rules are not published now. Following is a more detailed discussion of each of the three provisions that would be eliminated from this regulation under this alternative.

• *Including a "Severe" Step*—We could have proceeded with these regulations without providing a step that permits denial based on a finding that a child's impairment(s) is not "severe." Prior to the "Zebley" decision, we did not have such a step for children; we considered only whether the child was engaging in substantial gainful activity and, if not, whether his or her medically determinable impairment(s) met or equaled in severity an impairment in the listings. As we have explained in the "Supplementary Information" portion of this preamble, adding a severe step makes the childhood and adult evaluation processes more alike and, we believe, comports with the spirit of the "Zebley" decision to evaluate children comparably to adults and with our regulatory goal. In adult cases, we assess residual functional capacity only after we have found that the person has a severe impairment(s). Likewise, we believe that we must first determine that a child has an impairment(s) that is severe before we do an individualized functional assessment.

Even though the "Zebley" decision did not expressly require the addition of this step, the tenor of the decision is that children should be treated comparably to adults and thus directs the inclusion of this step in the process. There is no indication that the Supreme Court intended that children with minimal impairments should be treated differently than adults with such impairments. Further, in "Yuckert" the Court upheld the severity concept as a legitimate way to efficiently and validly screen out *de minimis* claims.

We could have achieved the same regulatory result without this step, but at a higher administrative cost. The step will increase the efficiency and reliability of the disability evaluation process by identifying those children whose impairments are so slight that they would not be found eligible even if we were to proceed to the more costly and time-consuming individualized functional assessment step.

Cost Considerations. There is no program benefit cost impact. The program cost would have been the same even if we had not included the step. We estimate that 10 percent of childhood disability claimants will be denied because their impairments do not more than minimally affect their ability to function in an age-appropriate manner. However, because their impairments are minimal these children would also be denied at the comparable severity step (step 4). Administrative savings will occur because it will not be necessary to conduct individualized functional assessments for children with no more than minimal impairments. We estimate that the inclusion of the severe step will save approximately $1.6 million per year in administrative costs.

• *Including a Functional Equivalence Process*—Our former policy on making equivalence determinations was criticized by the Supreme Court in "Zebley" because the policy did not adequately cover combinations of impairments, the effects of symptoms, and the effects of medication, among other things. The new functional equivalence policy responds to each of these criticisms. Moreover, the U.S. District Court for the Eastern District of Pennsylvania (where the "Zebley" case was remanded) approved an interim standard on May 5, 1990, which requires the consideration of a child's functioning and a comparison of this functional assessment with the functional consequences of impairments in the listings. The functional equivalence concept that is being incorporated into policy is also suggested by the listings themselves, which describe overall impairments of functioning (for example, a young child not functioning at one-half his or her chronological age) as well as specific functional impairments (for example, blindness).

Nevertheless, we could have devised rules that did not include functional equivalence, yet achieve the same outcome following an individualized functional assessment. However, aside from the foregoing reasons supporting the need for the rule, the functional equivalence process also provides administrative advantages as it allows us to make determinations of disability on the obvious functionally-impaired children without making us or them go through the complete development and documentation required under the new individualized functional assessment. Therefore, it achieves our regulatory goal at the lowest cost.

Cost Considerations. Program costs would not be affected. However, administrative savings would occur because the process is less complex than the comprehensive individualized functional assessment and allows the most severely impaired children to be paid earlier in the process. We estimate that the functional equivalence process will save approximately $700,000 per year in administrative funds.

• *Including Continuing Disability Review Process*—The *Zebley* decision did not explicitly mandate a revision of the continuing disability review process for children. However, our former rules for determining whether a child's disability continues contained the same policy that was struck down by the Supreme Court. In fact, the named plaintiff in "Zebley" was a child whose SSI benefits had been terminated. Therefore, there is no alternative to revising the continuing disability review rules; only whether we make the change now or later. Furthermore, individual experts who assisted us agreed that it is important that we have a mechanism to periodically reevaluate childhood claims because children can change rapidly. It is essential that we be able to reassess the functioning of eligible children as they age against the activities and behaviors appropriate to their age group.

Cost Considerations. The volume of continuing disability reviews and the administrative costs associated with such reviews will increase over the next 5 years because a greater proportion of the childhood population will be found eligible on application. Initially, we expect that the rate of cessations will be somewhat lower than in the past because nearly all children currently on the rolls were found disabled because they had impairments that met or equaled the listings.[1] Fewer of these children will be found no longer disabled, even if their impairments have medically improved, because they will now benefit from the incorporation of functional steps into the medical improvement review standard.

We expect many of the additional future allowances to be based on functional impairments that are medically less severe than the listings; therefore, the rate of cessation for this population may be somewhat higher than it was when the continuing disability review process for children was based only on the listings. Program costs would be at least $4 to $5 million higher if the continuing disability review process is not included in this regulation. The program savings associated with processing childhood continuing disability reviews exceed the administrative cost.

F. *Executive Order 12291, Section 2, General Requirements.* We believe that we have presented adequate information concerning the need for and consequences of this action. The foregoing discussions demonstrate that

[1] A small percentage of disabled children have been found disabled based on assessment of their functioning, pursuant to the interim standard we have been using as a result of the district court order in "Zebley." However, the vast majority of eligible children now on the rolls were found disabled under our prior regulatory standards.

our objective in these regulations is to provide the greatest potential benefits to society at the least net cost, by providing efficient, comprehensive, and up-to-date rules for identifying and assisting children who have impairments of comparable severity to impairments that would disable adults.

Executive Order 12612

We have reviewed these rules under the threshold criteria of Executive Order 12612 and have determined that they do not significantly affect the roles, rights and responsibilities of States.

When we considered the potential federalism implications of these regulations, we determined that the primary effect on the States is economic. The chart below projects State expenditures under both the high and low estimates.

[Dollars in millions]

	Fiscal year—					5-year total
	1991	1992	1993	1994	1995	
Low estimate:						
State SSI supplementation	$5	$15	$25	$30	$35	$110
State Medicaid benefits	19	68	106	141	179	513
Total State benefits	24	83	131	171	214	623
High estimate:						
State SSI supplementation	5	25	35	45	50	160
State Medicaid benefits	27	95	148	194	239	703
Total State benefits	32	120	183	239	289	863

The projected expenditures do not exceed 1 percent of total annual State revenues from all sources. Consequently, the "Zebley" regulations do not have a substantial direct effect on the States, and no federalism assessment is required.

Paperwork Reduction Act

These regulations do not impose reporting and recordkeeping requirements necessitating clearance by the Office of Management and Budget.

Regulatory Flexibility Act

We certify that these regulations will not have a significant economic impact on a substantial number of small entities because they will affect only individuals and States. Therefore, a regulatory flexibility analysis, as provided in the Regulatory Flexibility Act, 5 U.S.C. 601 through 612, is not required.

(Catalog of Federal Domestic Assistance Program No. 93.802, Disability Insurance.)

List of Subjects in 20 CFR Part 416

Administrative practice and procedure, Aged, Blind, Disability benefits, Public Assistance programs, Supplemental Security Income.

Dated: January 31, 1990.

Gwendolyn S. King,

Commissioner of Social Security.

Approved: February 5, 1991.

Louis W. Sullivan,

Secretary of Health and Human Services.

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

1. The authority citation for subpart I continues to read as follows:

Authority: Secs. 1102, 1614(a), 1619, 1631 (a) and (d)(1), and 1633 of the Social Security Act; 42 U.S.C. 1302, 1382c(a), 1382h, 1383 (a) and (d)(1), and 1383b; secs. 2, 5, 6, and 15 of Pub. L. 98-460, 98 Stat. 1794, 1801, 1802, and 1808.

2. Section 416.901 is amended by redesignating paragraphs (e) through (l) as paragraphs (f) through (m), revising the first sentence of paragraph (d), and adding a new paragraph (e) to read as follows:

§ 416.901 Scope of subpart.

* * * * *

(d) Our general rules on evaluating disability for adults filing new applications are stated in §§ 416.920 through 416.923. * * *

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

* * * * *

3. Section 416.902 is amended by adding the following two terms in alphabetical order:

§ 416.902 General definitions and terms for this subpart.

* * * * *

Adult means a person who is age 18 or older.

Child means a person who has not attained age 18.

* * * * *

4. Section 416.905 is amended by revising the section heading and by revising the last sentence of paragraph (a) to read as follows:

§ 416.905 Basic definition of disability for adults.

(a) * * * To determine whether you are able to do any other work, we consider your residual functional capacity and your age, education, and work experience (see § 416.920).

* * * * *

5. Section 416.906 is amended by revising the section heading and by adding a second sentence to read as follows:

§ 416.906 Basic definition of disability for children.

* * * We discuss our rules for determining disability in children in §§ 416.924, and 416.924a through 416.924e.

6. Section 416.913 is amended by adding new paragraphs (a)(6) and (c)(3), and revising paragraph (e) to read as follows:

§ 416.913 Medical evidence of your impairment.

(a) *Acceptable sources.* * * *

(6) A report of an interdisciplinary team that contains the evaluation and

signature of an acceptable medical source is also considered acceptable medical evidence.

* * * * *

(c) *Medical assessment.* * * *

(3) If you are a child, the medical source's opinion about your physical or mental abilities to function independently, appropriately, and effectively in an age-appropriate manner and to perform age-appropriate daily activities, as described in § 416.924c.

* * * * *

(e) *Information from other sources.* Information from other sources may also help us to understand how your impairment(s) affects your ability to work or, if you are a child, your ability to function independently, appropriately, and effectively in an age-appropriate manner. Other sources may include, and are not limited to—

(1) Public and private social welfare agencies and social workers;

(2) Observations by non-medical sources (for example, spouses, parents, siblings, other relatives, friends or neighbors, and clergy);

(3) Other practitioners (for example, nurse practitioners and physicians' assistants; naturopaths; and chiropractors);

(4) Therapists (for example, physical, occupational, or speech and language therapists); and

(5) Educational agencies and personnel (for example, school teachers, school psychologists who are not acceptable medical sources under paragraph (a), school counselors, preschools, early intervention teams, developmental centers, and daycare centers.

* * * * *

7. Section 416.916 is amended by revising the first sentence to read as follows:

§ 416.916 If you fail to submit medical and other evidence.

You (and, if you are a child, your parent, guardian, relative, or other person acting on your behalf) must cooperate in furnishing us with, or in helping us to obtain or identify, available medical or other evidence about your impairment(s). * * *

8. Section 416.920 is amended by revising the section heading to read as follows:

§ 416.920 Evaluation of disability of adults, in general.

9. Section 416.921 is amended by revising the section heading to read as follows:

§ 416.921 What we mean by a not severe impairment(s) in an adult.

* * * * *

10. Section 416.923 is amended by revising the reference at the end of the last sentence to read as follows:

§ 416.923 Multiple impairments.

* * * (see §§ 416.920 and 416.924).

11. Section 416.924 is revised to read as follows:

§ 416.924 How we determine disability for children.

(a) *Definition of comparable severity.* If you are a child, we will find you disabled if you are not engaging in substantial gainful activity and you have an impairment or combination of impairments that is of comparable severity to an impairment or combination of impairments that would disable an adult and which meets the duration requirement (see § 416.909). By the term "comparable severity," we mean that your physical or mental impairment(s) so limits your ability to function independently, appropriately, and effectively in an age-appropriate manner that your impairment(s) and the limitations resulting from it are comparable to those which would disable an adult. Specifically, your impairment(s) must substantially reduce, or if you are an infant from birth to the attainment of age 1, be reasonably expected to substantially reduce, your ability to—

(1) Grow, develop, or mature physically, mentally, or emotionally and, thus, to attain developmental milestones (see § 416.924a(c)(2)) at an age-appropriate rate; or

(2) Grow, develop, or mature physically, mentally, or emotionally and, thus, to engage in age-appropriate activities of daily living (see § 416.924a(c)(3)) in self-care, play and recreation, school and academics, vocational settings, peer relationships, or family life; or

(3) Acquire the skills needed to assume roles reasonably expected of adults.

(b) *Steps in evaluating disability.* We consider all evidence in your case record when we make a determination or decision whether you are disabled. If you allege more than one impairment, we will evaluate all the impairments for which we have evidence. Thus, we will consider the combined effects of all your impairments upon your overall health and ability to function. When you file a claim, we use the evaluation process set forth in (c) through (f) of this section. We follow a set order to determine whether you are disabled. If you are doing substantial gainful activity, we will determine that you are not disabled and not review your claim further. If you are not doing substantial gainful activity, we will consider your physical or mental impairment(s), first to see if you have an impairment or combination of impairments that is severe. If your impairment(s) is not severe, we will determine that you are not disabled and not review your claim further. If your impairment(s) is severe, we will review your claim further to see if you have an impairment(s) that meets or equals in severity any impairment that is listed in appendix 1 of subpart P of part 404 of this chapter, in which case, we will find you disabled. If you do not have such an impairment(s), we will do an indivdualized functional assessment and consider it together will all other relevant evidence to determine whether you are disabled. Once you have been found eligible for disability benefits, we follow a somewhat different procedure to determine whether your eligibility continues, as explained in § 416.994a.

(c) *If you are working.* 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 age, education, or work experience. (For our rules on how we decide whether you are engaging in substantial gainful activity, see §§ 416.971 through 416.976.)

(d) *You must have a severe impairment(s).* If you do not have any impairment or combination of impairments that causes more than a minimal limitation in your ability to function in an age-appropriate manner, we will find that you do not have a severe inpairment and are, therefore, not disabled.

(e) *When your impairment(s) meets or equals a listed impairment in Appendix 1.* The Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter is set at a level of severity that precludes any gainful activity or thats is comparable in severity to an impairment that would preclude an adult from engaging in any gainful activity. Therefore, if you have an impairment(s) which meets the duration requirement and is listed in appendix 1, or is equal to a listed impairment, we will find you disabled. We will not deny your claim on the basis of a finding that your impairment(s) does not meet the requirements for any listed impairment or is not equal in severity to any of the impairments listed in appendix 1. We explain our rules for deciding whether an impairment meets a listing in § 416.925. Our rules for how we decide whether an impairment(s) equals a listing are set forth in § 416.926.

(f) *Your impairment(s) must be of comparable severity to an impairment(s) that would disable an adult.* When we determine that your impairment(s) is severe, but that it does not meet or equal in severity any listed impairment, we will assess the impact of your impairment(s) on your overall ability to function independently, appropriately, and effectively in an age-appropriate manner. We will use this individualized functional assessment to decide whether you have an impairment(s) or comparable severity to an impairment(s) that would prevent an adult from engaging in substantial gainful activity and, thus, to determine whether or not you are disabled. We will use the individualized functional assessment in the following manner:

(1) If:

(i) Our evaluation of all the evidence in your claim shows that your impairment(s) so limits your physical or mental ability to function in an age-appropriate manner that your limitations are comparable to those which would disable an adult, and

(ii) Your impairment(s) meets the duration requirement, we will find you disabled.

(2) If we cannot find that your impairment(s) is comparable in severity to an impairment(s) that would make an adult disabled, or if your impairment(s) does not meet the duration requirement, we will find that you are not disabled.

12. A new § 416.924a is added to read as follows:

§ 416.924a Individualized functional assessment for children.

(a) *General.* If your impairment(s) is severe, but does not meet or equal in severity any of the listings in appendix 1 of subpart P of part 404, we will do an individualized functional assessment to determine whether you have an impairment or combination of impairments which would nevertheless be of comparable severity to an impairment(s) that would disable an adult. When we assess your functioning, we will consider all information in your case record that can help us determine the impact of your impairment(s) or your physical and mental functioning. We will consider the nature of your impairment(s), your age, your ability to be tested given your age, your ability to perform age-appropriate daily activities, and other relevant factors. (See §§ 416.924b through 416.924d.) We will assess the extent to which you are able to function independently, appropriately, and effectively in an age-appropriate manner despite your impairment(s), and use this assessment to determine whether you are disabled.

(b) *Basic considerations.* When we determine whether you are disabled using an individualized functional assessment, we will consider all relevant evidence in your case record. This may include medical evidence, school records, information from people who know you and can provide evidence about your functioning—such as your parents, caregivers, and teachers—and other evidence that can help us assess your functioning on a longitudinal basis.

(1) Medical evidence of your impairment(s) must describe symptoms, signs, or laboratory findings. The medical evidence may include formal testing that provides information about your development or functioning in terms of percentiles, percentages, standard deviations, or chronology (such as months of delay). Whenever possible, a medical source's finding should reflect consideration of information from your parents or other people who know you, as well as the medical source's findings and observations on examination; any discrepancies between formal test results and your customary behavior and daily activities should be duly noted and resolved.

(2) Your functional limitations may also be observed and reported by others. Parents (or other caregivers), and other family members may provide important evidence on how well you are functioning on a day-to-day basis. Educational and other intervention programs may be important sources of evidence about your functioning, and will often have documentary evidence in the form of evaluation instruments and other evidence from a variety of disciplines.

(c) *Terms used to describe functioning*— (1) *Age-appropriate activities.* As used in these regulations, the term "age-appropriate activities" is a comprehensive term that refers to what a child is expected to be able to do given his or her age. A child's activities may be described in terms of the achievement of "developmental milestones," "activities of daily living," or other such terms. Information about a child's activities creates a profile of how the child is functioning, i.e., what a child does, and thus what he or she is able to do. This makes possible a comparison between the child's profile and the activities that are age-appropriate for that child.

(2) *Developmental milestones.* The term "developmental milestones" refers to a child's expected principal developmental achievements at particular points in time. Ordinarily, failures to achieve developmental milestones are the most important indicators of impaired functioning from birth until the attainment of age 6, although they may be used to evaluate older children, especially school-age children.

(3) *Activities of daily living.* The term "activities of daily living" refers to those activities of children that involve continuity of purpose and action, and goal or task orientation; that is, the practical implementation of skills mastered at earlier ages. Ordinarily, activities of daily living are the most important indicators of functional limitations in children aged 6 to 18, although they may be used to evaluate younger children, especially preschool-age children.

(4) *Domains.* The terms "developmental domains" and "functional domains" refer to broad areas of development or functioning that can be identified in infancy and traced throughout a child's growth and maturation into adulthood. They describe the child's major spheres of activity—i.e., physical, cognitive, communicative, and social/emotional. In these regulations, the term "developmental domains" is generally used when we discuss younger children, i.e., from birth to age 6; the term "functional domains" is generally used when we discuss older children and young adolescents, i.e., from age 6 to age 16. (See § 416.924c for descriptions of the various domains as they pertain to the different age categories.)

13. A new § 416.924b is added to read as follows:

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

(a) *General.* In this regulation, we explain how we consider age when we decide whether you are disabled. Your age may or may not be a factor in our determination whether your impairment(s) meets or equals a listing, depending on the listing we use for comparison. However, your age is always an important factor when we decide whether you are disabled based on an individualized functional assessment. Except in the case of certain premature infants, as described in paragraph (c) of this section, age means chronological age.

(1) When we determine whether you have an impairment or combination of impairments that is severe, we will always consider the significance of your impairment(s) in relation to your age.

(2) The Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter contains examples of impairments that we consider of such

significance that they prevent a child from functioning independently, appropriately, and effectively in an age-appropriate manner. Therefore, we will usually decide whether your impairment meets a listing without giving special consideration to your age. However, several listings are divided into age categories. If the listing appropriate for evaluating your impairment includes such age categories, we will evaluate your impairment under the criteria for your age when we decide whether your impairment meets that listing.

(3) When we compare an unlisted impairment or combination of impairments with a listed impairment to determine whether you have an impairment(s) which equals a listing, the way in which we consider your age will depend on the listing we use for comparison. We will use the same principles for considering your age as in paragraph (a)(2) of this section; that is, we will consider your age only if we are comparing your impairment(a) to a listing that includes specific age categories.

(4) When we determine whether you have an impairment(s) which, though not meeting or equaling the listings, is of comparable severity to an impairment that would disable an adult, we will always consider the significance of your impairment(s) in relation to your age. We will consider the functions, behaviors, and activities that are appropriate to your age, and will evaluate the effect of your impairment(s), either alone or in conjunction with other relevant factors, on your ability to perform these functions, behaviors, and activities. (We explain how we do this individualized functional assessment in §§ 416.924a, 416.924c and 416.924e.)

(b) *Age categories.* When we determine whether you are functioning independently, appropriately, and effectively in an age-appropriate manner, we will consider your age in the following categories; however, we will not apply these age categories mechanically in borderline situations.

(1) Newborn and young infants (birth to attainment of age 1).

(2) Older infants and toddlers (age 1 to attainment of age 3).

(3) Children (age 3 to attainment of age 18), considered according to the following subcategories:

(i) Preschool children (age 3 to attainment of age 6),

(ii) School-age children (age 6 to attainment of age 12),

(iii) Young adolescents (age 12 to attainment of age 16), and

(iv) Older adolescents (age 16 to attainment of age 18).

(c) *Evaluation of premature and low birth weight infants.* We generally use chronological age (that is, a child's age based on birth date) when we decide whether, and the extent to which, a physical or mental impairment(s) affects a child's ability to function independently, appropriately, and effectively in an age-appropriate manner. However, if you were born prematurely, we may consider you to be younger than your chronological age. We consider an infant born at less than 37 weeks' gestation to be "premature-by-date." We consider prematurity as follows—

(1) We will find children born prematurely who satisfy the weight guidelines for establishing functional equivalence in § 416.926a(d)(10) (i.e., weight of less than 1200 grams at birth) disabled at least until attainment of the chronological age of 12 months. The number of weeks of prematurity will not be a factor in our determination of disability.

(2) We will find children born prematurely who satisfy the weight-and-size guidelines for establishing functional equivalence in § 416.926a(d)(11) (i.e., weight of at least 1200 grams but less than 2000 grams at birth and at least four weeks "small for gestational age") disabled at least until attainment of the chronological age of 12 months. When we decide the extent to which a child was "small for gestational age" at birth, we will consider the child's actual gestational age, as shown by appropriate medical evidence.

(3) We evaluate the claims of other children who were born prematurely in the same way that we evaluate the claims of infants who were not premature. We will apply the following principles—

(i) If we are evaluating an impairment of development, we will use a "corrected" chronological age, that is, the chronological age adjusted by the period of gestational prematurity. We compute the corrected chronological age by subtracting the number of weeks of prematurity from the chronological age. We use this corrected age when we evaluate developmental delay in premature children until it is no longer a significant factor; generally, at about chronological age 2.

(ii) If we are evaluating an impairment of linear growth, such as under the listing in § 100.00, appendix 1 of subpart P of part 404 of this chapter, we refer to neonatal growth charts which have been developed to evaluate growth in premature-by-date infants. Because these growth charts already take prematurity into account, we do not compute a corrected age in such cases.

(d) *Impact of severe impairment(s) on younger children and older adolescents.* Although a child may become disabled at any age, impairments of similar severity may have different effects on children of different ages in determining whether a child has an impairment of comparable severity to an adult. The following guidelines apply to the evaluation of the effects of impairments on children of different ages, especially very young children and children approaching adulthood.

(1) In general, the younger you are, the greater we will consider the impact of your impairment(s) on your ability to grow and develop. Although various kinds of growth and development occur throughout childhood and adolescence, the earliest years, from birth to approximately attainment of age 6, are characterized by complex and rapid changes; for example, learning to walk, talk, and care for basic physical and emotional needs. The development of fundamental skills both within and across functional domains is a cumulative process founded upon skills acquired at each stage of a child's life. A child's ability to acquire or perform these skills ultimately determines his or her ability to master learning tasks in school and more complex physical activities and, eventually, affects the ability to work. Therefore, deficits of function resulting from impairments that occur before the attainment of age 6 may have a potentially greater, more limiting effect on a child's overall growth and development than impairments that occur later in life; and such deficits are increasingly significant with decreasing age.

(2) Furthermore, the mastery of skills in early childhood is a highly interactive and interdependent process within a child. This interdependence is especially true of development in certain areas; e.g., cognitive skill deficits may affect communications, and social and emotional deficits may affect cognitive and communicative development. This interdependent process also requires proper functioning in areas that may not be obviously relevant to the acquisition of the skill. For example, physical mobility is affected by how well a child sees; therefore, visual impairment, especially in a young child, can affect the way a child acquires certain motor skills even though the child does not have a specific motor impairment. Similarly, emotional bonding to parents can be affected by how well a child hears. Therefore, the impact of such seemingly isolated impairments can have implications for the overall development of the youngest children.

Generally, the more global effect of these kinds of impairments on development diminishes with increasing age.

(3) The potentially greater impact of physical or mental impairments on the youngest children is analogous to the consideration of age in the rules for determining whether an adult has the ability to make an adjustment to other work, only in the opposite way. Whereas the older an adult is, the more significant the impact of a physical or mental impairment on his or her ability to adjust to other work, the reverse is generally true in children. As children become older, they generally (though not the reverse is generally true in children. As children closely approach age 18 (i.e., by about age 16) they are comparable to adults in the age category called "younger persons," i.e., those in the age 18–45 category (see § 416.962(b)), in their physical and mental makeup and potential.

14. A new § 416.924c is added to read as follows:

§ 416.924c Functioning in children.

(a) *General.* (1) When we evaluate your functioning, we will consider all of your mental and physical limitations that result from your impairments(s). We will evaluate the extent to which you can engage in age-appropriate activities in an independent, appropriate, and effective manner and, when applicable, whether you can do these things on a sustained basis appropriate to your age.

(2) the following are the domains of development or functioning, or specific behaviors that may be addressed in an individualized functional assessment:

(i) Cognition;

(ii) Communication;

(iii) Motor abilities;

(iv) Social abilities;

(v) Responsiveness to stimuli (in children from birth to the attainment of age 1);

(vi) Personal/behavioral patterns (in children from age 1 to the attainment of age 18); and

(vii) Concentration, persistence, and pace in task completion (in children from age 3 to the attainment of age 18).

(3) When your impairment(s) affects a particular domain of development or functioning, or a behavior, we will consider the extent of your impairment-related limitations in that domain or behavior as well as how well you are able to do age-appropriate activities despite your limitations. We will also consider how your impairment(s) in one domain affects your development or functioning in other domains.

(4) We will consider whether any help or intervention that you need from others to enable you to do any particular activity is appropriate to your age.

(5) The guidelines in paragraphs (b) through (f) of this section describe, in terms of the age categories outlined in § 416.924b(b), the domains of development or function and the behaviors used in doing an individualized functional assessment, and the general kinds of age-related activities that may be affected by your impairment(s). (See § 416.924e for guidelines for determining disability using an individualized functional assessment.)

(b) *Newborns and young infants (birth to attainment of age 1).* Children in this age group are evaluated in an individualized functional assessment in terms of four developmental domains and an area of behavior important to newborns and young infants.

(1) Cognitive development, e.g., your ability to begin to organize and regulate how you feel and the ways you react to your environment;

(2) Communicative development (includes speech and language), e.g., your ability to communicate with intention through visual, motor, and vocal exchanges;

(3) Motor development (includes gross and fine motor skills), e.g., your ability to explore your environment by moving your body, and your ability to manipulate your environment by using your hands;

(4) Social development, e.g., your ability to form and maintain relationships with your primary caregivers;

(5) Responsiveness to stimuli, e.g., your ability to respond appropriately to visual, auditory, or tactile stimulation.

(c) *Older infants and toddlers (age 1 to attainment of age 3).* Children in this age group are evaluated in an individualized functional assessment in terms of five developmental domains.

(1) Cognitive development, e.g., your ability to understand by responding to increasingly complex requests, instructions or questions, by referring to yourself, and things around you by pointing and eventually by naming, and by copying things or imitating actions shown to you by others;

(2) Communicative development (includes speech and language), e.g., your ability to communicate by understanding, imitating, and using an increasing number of intelligible words and eventually forming two-to-four word sentences;

(3) Motor development (includes gross and fine motor skills), e.g., your ability to move in your environment using your body with steadily increasing dexterity and independence from support by others, and your ability to use your hands to do something that you want or get something that you need;

(4) Social development, e.g., your ability to express normal dependence upon, and emotional bonding with, your primary caregivers as well as increasing independence from them;

(5) Personal/behavioral development, e.g., your ability to help yourself or to cooperate with others in taking care of your personal needs, in adapting to your environment, and in learning new skills.

(d) *Preschool children (age 3 to attainment of age 6).* Children in this age group are evaluated in an individualized functional assessment in terms of five developmental domains and an area of behavior important to preschool children.

(1) Cognitive development, e.g., your ability to understand, to reason and to solve problems, and to use acquired knowledge and concepts;

(2) Communicative development (includes speech and language), e.g., your ability to communicate by telling, requesting, predicting, and relating information, by following and giving directions, by describing actions and functions, and by expressing your needs, feelings, and preferences in an increasingly intelligible manner;

(3) Motor development (includes gross and fine motor skills), e.g., your ability to move and use your arms and legs in increasingly more intricate and coordinated activity, or your ability to use your hands with increasing coordination to manipulate small objects during play;

(4) Social development, e.g., your ability to respond to your social environment through appropriate self-control and increasingly complex interpersonal behaviors, such as sharing, cooperating, helping, and relating to a group;

(5) Personal/behavioral development, e.g., your ability to help yourself or to cooperate with others in taking care of your personal needs, in adapting to your environment, in learning new skills;

(6) Concentration, persistence, and pace, e.g., your ability to engage in an activity, such as dressing or playing, and to sustain the activity for a period of time and at a pace appropriate to your age.

(e) *School-age children (age 6 to attainment of age 12).* Children in this age group are evaluated in an individualized functional assessment in terms of five functional domains and an area of behavior important to school-age children.

(1) Cognitive function, e.g., your ability to progress in learning the skills

involved in reading, writing, and mathematics;

(2) Communicative function (includes speech and language), e.g., your ability to communicate pragmatically (i.e., to meet your needs) or conversationally (i.e., to exchange information or ideas in your classroom, with peers or family);

(3) Motor function (includes gross and fine motor skills), e.g., your ability to engage in the physical activities involved in play, physical education, and self-care appropriate to your age;

(4) Social function, e.g., your ability to play alone, or with another child, or in a group; to develop friendships, and to relate to your siblings and parents or caregivers;

(5) Personal/behavioral function, e.g., your ability to help yourself or to cooperate with others in taking care of your personal needs and safety; to understand authority relationships and school rules; to develop a sense of responsibility for yourself and respect for others; and to learn new skills;

(6) Concentration, persistence, and pace, e.g., your ability to engage in an activity, such as playing or reading, and to sustain the activity for a period of time and at a pace appropriate to your age.

(f) *Young adolescents (age 12 to attainment of age 16).* Children in this age group are evaluated in an individualized functional assessment in terms of five functional domains and an area of behavior important to young adolescents.

(1) Cognitive function, e.g., your ability to progress in applying the skills involved in reading, writing, and mathematics, your reasoning and problem-solving abilities;

(2) Communicative function (includes speech and language), e.g., your ability to communicate pragmatically (i.e., to meet your needs) and conversationally (i.e., to exchange information or ideas in your school classes, with peers or family);

(3) Motor function (includes gross and fine motor skills), e.g., your ability to engage in the physical activities involved in physical education, sports, social events, and self-care appropriate to your age;

(4) Social function, e.g., your ability to develop friendships, to relate to peer groups, and to reconcile conflicts between yourself and peers or family members;

(5) Personal/behavioral function, e.g., your ability to help yourself in taking care of your personal needs and safety, to respond appropriately to authority and school rules, and to learn new skills;

(6) Concentration, persistence, and pace, e.g., your ability to engage in an activity, such as studying or practicing a sport, and to sustain the activity for a period of time and at a pace appropriate to your age.

(g) *Older adolescents (age 16 to attainment of age 18).* (1) Descriptive information about your activities of daily living will tell us about the nature and age-appropriateness of your activities with respect to your cognitive functioning, communicative functioning, motor functioning, social functioning, personal/behavioral functioning, and your concentration, persistence and pace in school or work-related activities.

(2) As you approach adulthood (i.e., beginning at about age 16) we will consider some of your school activities as evidence of your ability to function in a job setting. For example, we will consider your ability to understand, carry out, and remember short instructions and work-like procedures in the classroom as evidence of your ability to do these things in a job. We will consider your ability to maintain attention for extended periods of time and to sustain an ordinary daily routine without special supervision as evidence of your ability to do these things in a job. We will consider your ability to deal with authority figures and to follow directions in school, responding appropriately to correction or criticism, as an indication of your ability to deal with supervision on a job. We will consider your ability to regulate your mood and behavior in various school settings as some indication of your ability to deal with change in a work setting. We will consider your ability to engage in physical activities both in and out of school as it relates to your ability to perform the physical demands of work. We will also consider whether you have acquired any skills from specific vocational education and whether you have pursued any part-time or stay-in-school employment.

(3) If you are working or have worked, we will evaluate such things as: the physical activities in which you are engaged on the job; the regularity and punctuality of your attendance; your ability to follow directions and deal with supervisors; and your ability to work independently and to deal with others in your job.

15. A new § 416.924d is added to read as follows:

§ 416.924d Other factors we will consider in the individualized functional assessment.

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

(b) *Chronic illness.* If you require repeated hospitalizations or frequent outpatient care with supportive therapy for a chronic impairment(s), we will consider this need for treatment as a factor in our determination of your overall ability to function. If your hospitalizations are so long or so frequent that they interfere with your overall functioning on a longitudinal basis, or your outpatient care significantly interferes with your daily activities (either because of its frequency, its effects on your functioning, or both), we may find that you are disabled because of your need for, or the level of, treatment for your chronic illness.

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

(d) *Effects of structured or highly supportive settings.* Children with severe impairments may spend much of their time in structured or highly supportive settings. A structured or highly supportive setting may be your own home, in which family members make extraordinary adjustments to accommodate your impairments; or your classroom at school, whether a regular class in which you are accommodated, or a special classroom for children with similar needs; or a residential facility or school where you live for a period of time. Children with chronic impairments also commonly have their lives structued in such a way as to minimize

stress and reduce their symptoms or signs, and may be relatively free of obvious symptoms or signs of impairment; others may continue to have persistent pain, fatigue, decreased energy, or other symptoms or signs, though at a lesser level of severity. Such children may be more impaired in their overall ability to function in an age-appropriate manner than their symptoms and signs would indicate. Therefore, if your symptoms or signs are controlled or reduced by the environment in which you live, we will consider your ability to function independently, appropriately, and effectively in an age-appropriate manner outside of this highly structured setting.

(e) *Adaptations.* We will consider the nature and extent of any other adaptations that are made for you in order to enable you to function. Such adaptations may include assistive devices, appliances, or technology. Some adaptive devices are relatively unobtrusive and may increase or restore functioning; examples of such devices may include eyeglasses, hearing aids, ankle-foot orthoses, and hand or foot splints. Others may be less effective or may impose additional limitations that interfere with performance of age-appropriate activities (e.g., specially adapted or custom-made tools, utensils, or support for self-care activities such as bathing, feeding, toileting, dressing, and sleeping). When we evaluate your overall ability to function independently, appropriately, and effectively in an age-appropriate manner with an adaptive device or other adaptation, we will consider such things as the degree to which the adaptation enables you to function and any additional limitations caused by the adaptation.

(f) *Multidisciplinary therapy.* You may need frequent and ongoing therapy from more than one kind of health care professional in order to maintain or improve your functional status. We call this multidisciplinary therapy, and it may include occupational, physical, or speech and language therapy, special nursing services, psychotherapy, or psychosocial counseling. Frequent and continuous therapy, although intended to improve your functioning, may also interfere significantly in your opportunities to engage in, and sustain, age-appropriate activities. If you receive such therapy at school during a normal school day, it may or may not interfere significantly with your doing age-appropriate activities. If you must frequently interrupt your activities at school or at home in order to go for therapy, these interruptions may interfere with your development and age-appropriate functioning. When we determine whether you have an impairment(s) of comparable severity to an impairment(s) that would disable an adult, we will consider the frequency of any multidisciplinary therapy that you must have, how long you have needed the therapy or will need the therapy, and the extent to which it interferes with your age-appropriate functioning.

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

(2) The fact that you are able to attend school will not, in itself, be an indication that you are not disabled. We will consider the circumstances of your school attendance, such as your ability to function independently in a classroom setting in an age-appropriate manner. Likewise, the fact that you are in a special education classroom setting, or that you are not in such a setting, will not in itself establish your actual limitations or abilities. We will consider the fact of such placement or lack of placement in the context of the remainder of the evidence in your case record.

(3) However, if you are unable to attend school on a regular basis because of your impairment(s), we will consider this when we determine whether you are able to function in an age-appropriate manner.

(h) *Treatment and intervention, in general.* With adequate treatment or intervention, some children not only have their symptoms and signs reduced, but also return to or achieve a level of functioning that is consistent with the norms for their age. We will, therefore, evaluate the effects of your treatment or intervention to determine the actual outcome of the treatment or intervention in your particular case.

16. A new § 416.924e is added to read as follows:

§ 416.924e Guidelines for determining disability using the individualized functional assessment.

(a) *General.* The guidelines in this section are provided as a framework for deciding whether a child who has a severe impairment(s) that does not meet or equal the listings nevertheless has an impairment(s) that is of comparable severity to one that would disable an adult, and is, therefore, disabled. The guidelines illustrate a level of impairment severity that is generally, though not invariably, sufficient to establish comparable severity; i.e., to establish that there is an impairment or combination of impairments that so limits your ability to function independently, appropriately, and effectively in an age-appropriate manner that the resulting functional limitations are comparable to those that would disable an adult. The examples in this section are only guidelines to illustrate severity and are not all-inclusive rules. The determination of your claim is based on all relevant evidence in the case record, using the principles and guidance in §§ 416.924 through 416.924d on a case-by-case basis.

(b) *How we describe functional limitations.* The terms used in this section to describe functional severity of both physical and mental impairments employ as a frame of reference the terminology and definitions in the childhood mental listings in 112.00 of the Listing of Impairments of appendix 1 to subpart P of part 404 of this chapter. Hence, the examples of "moderate" and other impairments are derived from a comparison with the "marked" levels of functional limitation in the listings. As in those listings, "marked" and "moderate" are not the number of activities or functions which are restricted, but the overall degree of restriction or combination of restrictions. A marked or moderate limitation may arise when several activities or functions are impaired, or even when only one is impaired.

(1) If you are a younger child, from birth to the attainment of age 3, your functional limitations will generally be described in the examples in terms of a developmental delay, or the fraction or percentage of your chronological age that represents the levels of your functioning; e.g., three-fourths of chronological age. If you are functioning in one of the domains or behaviors described for your age in § 416.924c at more than one-half, but not more than two-thirds, of your chronological age, you are said to have a marked impairment. If you are functioning in one of the domains or behaviors described for your age in § 416.924c at more than two-thirds, but not more than three-fourths of your chronological age, we describe your impairment as moderate.

(2) If you are an older child or young adolescent, from age 3 to the attainment of age 16, your impairment(s) will generally be described in the examples in terms of specific kinds of age-appropriate activities, functional abilities, or abnormal behaviors. Although it is sometimes appropriate to

evaluate severity in this age group in the same terms as are used in paragraph (b)(1) of this section, which describes moderate limitation of functioning in terms of a level that is more than two-thirds but not more than three-fourths of a child's chronological age, the older a child becomes, the less precise are the means of determining this kind of profile. The spectrum of limitations that may constitute "moderate" impairment in this age group ranges from limitations that may be close to the "marked" level in severity to limitations that may be close to the "mild" level and, thus, considerably less limiting. Use of the examples as guides in the evaluation of older children and young adolescents, therefore, requires careful evaluation and judgment in each individual case, taking into account the child's age (as explained in § 416.924b) and all other relevant factors described in §§ 416.924 through 416.924d.

(3) If you are an older adolescent, aged 16 to the attainment of age 18, functional limitations are generally evaluated in terms of physical and mental activities that are the same as, or similar to, activities of young adults. Hence, the guidance and examples in paragraph (d) of this section focus on physical abilities (exertional and nonexertional) and mental abilities associated with work activities, as described in §§ 416.921, 416.945, and 416.967. However, assessment of an older adolescent's abilities and limitations is to be made in an age-appropriate context, as demonstrated by performance in school, work, and other relevant settings.

(c) *How we evaluate children from birth to attainment of age 16.*—(1) *Young children (birth to attainment of age 3).* If you are a newborn or young infant (birth to the attainment of age 1), we evaluate the severity of your impairment(s) with respect to four developmental domains (cognitive, communicative, motor, and social development) and your responsiveness to stimuli. If you are an older infant or toddler (age 1 to the attainment of age 3), we evaluate the severity of your impairment(s) with respect to five developmental domains (cognitive, communicative, motor, social, and personal/behavioral development). (See § 416.924c (b) and (c) for descriptions of the domains and behaviors appropriate to each age group.) Our evaluation of severity is based on comparison with the descriptors of functional severity in Listings 112.02–112.12 for childhood mental disorders: Failure to achieve development of no more than one-half your chronological age in a single domain, or of no more than two-thirds your chronological age in two domains represents listing-level severity. Examples of when we will generally find comparable severity (as defined in (a) of this section) and, thus, find you disabled include the following:

(i) You are functioning in one domain (e.g., motor development) at a level that is more than one-half, but not more than two-thirds of the normal age-appropriate level for a child your age and you are functioning in another domain (e.g., communicative) at a level that is more than two-thirds but not more than three-fourths of the normal age-appropriate level for a child your age; or

(ii) You are functioning in three domains (e.g., cognitive, motor, and social development) at a level that is more than two-thirds, but not more than three-fourths of the normal age-appropriate level for a child your age.

(2) *Older children and young adolescents, age 3 to attainment of age 16.* If you are in this age group, we evaluate the severity of your impairment(s) with respect to five functional domains (cognitive, communicative, motor, social, and personal/behavioral function), and your concentration, persistence, and pace in the completion of age-appropriate tasks. (See § 416.924c (d) through (f) for descriptions of the domains and behaviors appropriate to this age group.) The level of severity illustrating the term "moderate," and the overall level of disability at less than the listing level, are based on comparison with the listing-level requirement for marked impairment in two domains, as described in 112.00C of the Listing of Impairments in appendix 1 of subpart P of the Regulations part 404 of this chapter. In the case of preschoolers (age 3 to the attainment of age 6), it may be appropriate to evaluate the level of severity in terms of developmental age, as in younger children. Examples of when we will generally find comparable severity and, thus, find you disabled include the following:

(i) You are functioning at the marked level in one domain (e.g., in the domain of social functioning, you are generally unable to maintain age-appropriate relationships with peers and adults, with frequent serious conflicts with your family, classmates, and teachers) *and* you are functioning at the moderate level in another domain (e.g., in the domain of personal/behavioral functioning, you are frequently unable adequately to perform major age-appropriate activities of daily living); or

(ii) You are functioning at the moderate level in three domains (e.g., in cognitive functioning, you have a valid full scale IQ of 74; in social functioning, you have limited age-appropriate relationships with peers and adults, with occasional serious conflicts with family, classmates, teachers, and others; and with respect to concentration, persistence and pace, you are frequently unable to complete age-appropriate complex tasks, and occasionally unable to perform simple age-appropriate tasks adequately).

(d) *How we evaluate severity for older adolescents, from age 16 to attainment of age 18.*—(1) *General.* As we explain in § 416.924c(g), children aged 16 to 18 are closely approaching adulthood and can be evaluated in terms that are the same as, or similar to, those used for the evaluation of the youngest adults. Children in this age range who do not have impairment-related limitations are ordinarily expected to be able to do the kinds of physical and mental activities expected of individuals who are at least 18 years old.

(i) The discussions in this section are predicated on the foregoing principles. They describe limitations of physical and mental functions that are associated with, or related to, functions in the workplace, as demonstrated by a child's performance of age-appropriate activities in age-appropriate contexts, such as school, part-time or full-time work, vocational programs, and organized activities. (See, also, § 416.924c(g).)

(ii) As in the examples for younger children, the guidance for evaluating older adolescents is not intended to be all-inclusive, or a standard by which all cases must be judged. Each case must be evaluated on its own merits using the principles and guidelines of all of the regulations addressing childhood disability.

(2) *Mental functions.* We will consider your mental capacities to perform on a sustained basis (i.e., 8 hours a day, 5 days a week) the general kinds of mental activities that we evaluate for adults. We will consider such things as your ability to understand, carry out, and remember simple instructions; to maintain attention for extended periods of time; to use judgment; to make simple decisions; to take necessary safety precautions; to respond appropriately to supervision and peers (e.g., by being able to accept instructions and criticism, by not requiring special supervision, and by not being unduly distracted by your peers or unduly distracting to them in a school or work setting); and dealing with changes in your routine school or work setting. (See, also § 416.924c(g).)

(3) *Physical functions.* When we evaluate the impact of your impairment(s) on your ability to function in an age-appropriate manner, we will consider your physical capacity to perform on a sustained basis (i.e., 8 hours a day, 5 days a week) the types and ranges of exertional and nonexertional activities that we evaluate for adults; e.g., sitting, standing, walking, lifting, carrying, pushing, pulling, reaching, handling, manipulating, seeing, hearing, and speaking. (See, also § 416.924c(g).)

(4) *Evaluation.* If an individualized functional assessment shows that you experience a substantial loss or deficit of capacity to perform the age-appropriate mental or physical activities described, we will find that your impairment(s) seriously interferes with your ability to function independently, appropriately, and effectively in an age-appropriate manner, and that it has substantially reduced your ability to acquire the skills needed to assume roles reasonably expected of adults. Therefore, we will conclude that you have an impairment(s) that is comparable in severity to an impairment that would disable an adult, and that you are disabled.

17. Section 416.926 is amended by revising the section heading to read as follows:

§ 416.926 Medical equivalence for adults.

18. A new § 416.926a is added to read as follows:

§ 416.926a Equivalence for children.

(a) *General.* If you are a child and you do not have an impairment that meets the requirements of a listing, we will determine whether you have an impairment or combination of impairments that is equivalent in severity to any listed impairment in appendix 1 of subpart P of part 404, as set forth in this section. While all possible impairments are not addressed within the Listing of Impairments, within the listed impairments are all the physical and mental functional limitations, i.e., what a child cannot do as a result of an impairment, that are considered severe enough to prevent a child from functioning independently, appropriately, and effectively in an age-appropriate manner. We will compare the symptoms, signs, and laboratory findings about your impairment(s), including, where appropriate, any functional limitations that result from your medically determinable impairment(s), with the corresponding criteria shown for any listed impairment. When we make an equivalence decision, we will consider all relevant evidence in your case record.

(b) *How we determine the equivalence of impairments for children.* Equivalence can be found in three ways:

(1) If you have an impairment that is described in the Listing of Impairments in Appendix 1 of Subpart P of Part 404, but:

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

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

we will nevertheless find that your impairment is equivalent to that listing if you have other medical findings related to your impairment that are at least of equal medical significance.

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

(3) If we cannot find equivalence under either of the foregoing provisions, we will assess the overall functional limitations that result from your impairment(s), i.e., what you cannot do because of your impairment(s). We will compare the functional limitation(s) resulting from your impairment(s) with the functional consequences of any listed impairment which includes the same functional limitations. If the functional limitation(s) resulting from your impairment(s) is the same as the disabling functional consequences of a listed impairment, we will find that your impairment(s) is equivalent to that listed impairment. When we make a determination or decision using this rule, the primary focus will be on the disabling consequences of your impairment(s), as long as there is a direct, medically determinable cause for these consequences.

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

(d) *Examples of impairments of children that are functionally equivalent to the listings.* The following are some examples of consequences of impairments that are functionally equivalent to listed impairments. The consequences of each child's impairments must be assessed to determine whether they are functionally equivalent to those of a listed impairment and should not be limited to the examples below.

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

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

(3) Daily need for a life-sustaining device (e.g., mechanical ventilation), at home or elsewhere, lasting or expected to last 12 months.

(4) Complete inability to stand and walk.

(5) Marked inability to stand and walk; e.g., ambulation possible only with obligatory bilateral upper limb assistance.

(6) Complete inability to perform self-care skills.

(7) Marked restriction of age-appropriate activities of daily living and marked difficulties in maintaining age-appropriate social functioning.

(8) Impairment causing complete inability to function independently outside the area of one's home within age-appropriate norms.

(9) Requirement for 24-hour-a-day supervision for medical or behavioral reasons, lasting or expected to last 12 months.

(10) Premature infants (i.e., 37 weeks or less) weighing less than 1200 grams at birth, until attainment of 1 year of age.

(11) Premature infants weighing at least 1200 but less than 2000 grams at birth *and* who are at least 4 weeks small for gestational age, until attainment of 1 year of age.

(12) In an infant who has not attained age 1 year, any physical disorder that satisfies the requirements of Listing 112.12.

(13) Major congenital organ dysfunction (e.g., congenital heart disease) which could be expected to result in death within the first year of life without surgical correction, until attainment of 1 year of age.

(14) Tracheostomy in a child who has not attained age 3.

(15) Gross microcephaly of greater than 3 standard deviations.

19. Section 416.994(c) is removed. Section 416.994(d) is redesignated as § 416.994(c). The section heading of § 416.994, and the text of § 416.994(a), § 416.994(b)(4)(ii), and redesignated § 416.994(c) are revised to read as follows:

§ 416.994 How we will decide whether your disability continues or ends, disabled adults.

(a) *General.* There is a statutory requirement that, if you are entitled to disability benefits, your continued entitlement to such benefits must be reviewed periodically. Our rules for deciding whether your disability continues are set forth in paragraph (b) of this section. Additional rules apply if you were found disabled under a State plan, as set forth in paragraph (c) of this section.

* * * * *

(b) *Disabled persons age 18 or over (adults).*

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(4) *Second group of exceptions to medical improvement.*

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(ii) *You do not cooperate with us.* If there is a question about whether you continue to be disabled and we ask you to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 416.1411 discusses how we will decide whether you have good cause for failure to cooperate. * * *

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(c) *Persons who were found disabled under a State plan.* If you became entitled to benefits because you were found to be disabled under a State plan, we will first evaluate your impairment(s) under the rules explained in paragraph (b) of this section. We will apply the same steps as described in paragraph (b) of this section to the last decision granting or affirming entitlement to benefits under the State plan. If we are not able to find that your disability continues on the basis of these rules, we will then evaluate your impairment(s) under the appropriate State plan. If we are not able to find that your disability continues under these State plan criteria, we will find that your disability ends. Disability will be found to end the month the evidence shows that you are no longer disabled under the criteria in paragraph (b) of this section (or appropriate State plan criteria), subject to the rules set out in paragraph (b)(6) of this section.

20. A new § 416.994a is added to read as follows:

§ 416.994a How we will decide whether your disability continues or ends, disabled children.

(a) *Evaluation of continuing disability, in general.* There is a statutory requirement that, if you are eligible for disability benefits as a disabled child, your continued eligibility for such benefits must be reviewed periodically. There are a number of factors we consider when we decide whether your disability continues.

(1) If your current impairment(s) does not meet or equal any current listing, we determine whether there has been any medical improvement in your impairment(s) that is "related to the ability to work," i.e., your ability to function independently, appropriately, and effectively in an age-appropriate manner. (We define the term "medical improvement" in paragraph (c). We define the term "related to the ability to work" as it applies to children in paragraph (d).) If there has not been any medical improvement in your impairment(s), or if the medical improvement is not related to the ability to work, we will generally find that your disability continues; there are exceptions to this general rule, which we describe in paragraphs (f) and (g). If there has been medical improvement related to the ability to work, or when certain exceptions apply, we will determine whether you are currently disabled under the rules in §§ 416.924 through 416.924e. Even where medical improvement related to your ability to work or an exception applies, in most cases, we will find that your disability has ended only if we also find that you are not currently disabled.

(2) Our determinations and decisions under this section will be made on a neutral basis, without any initial inference as to the presence or absence of disability being drawn from the fact that you have been previously found disabled. We will consider all evidence you submit, as well as all evidence we obtain from your treating physician(s) and other medical and nonmedical sources. What constitutes "evidence" and our procedures for obtaining it are set out in §§ 416.912 through 416.918. Our determination regarding whether your disability continues will be made on the basis of the weight of the evidence.

(b) *Sequence of evaluation.* To assure that disability reviews are carried out in a uniform manner, that decisions of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally, and are fully documented, we follow specific steps in determining whether your disability continues. If we can make a favorable determination or decision at any point in the sequence, we do not review further. The steps are:

(1) *Do you have an impairment(s) that meets or equals the severity of any impairment listed in appendix 1 of subpart P of part 404 of this chapter?* If you have an impairment that meets a current listing, or an impairment or combination of impairments that is of equivalent severity to a current listing, we will find that your disability continues. For our rules on how we determine whether impairments meet or are equivalent to listings, see §§ 416.925 and 416.926.

(2) *Has there been medical improvement in your condition(s)?* If you do not have an impairment(s) that meets or is equivalent to any current listing we will determine whether there has been medical improvement in your impairment(s) since our most recent favorable determination or decision. (The term "medical improvement" is defined in paragraph (c).) If there has been medical improvement, as shown by a decrease in the medical severity of your impairment(s), we will proceed to the next step. If there has been no decrease in the medical severity of your impairment(s), we will find that your disability continues, unless one of the exceptions to medical improvement described in (f) or (g) applies.

(i) If one of the first group of exceptions to medical improvement applies, we will proceed to step 4.

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

(3) *If there has been medical improvement, is it related to the ability to work?* If there has been medical improvement in your impairment(s), we will determine whether your medical improvement is related to the ability to work, as defined for children in (d). If it is, we will proceed to the next step. If the medical improvement of your

impairment(s) is not related to the ability to work, we will find that your disability continues, unless one of the exceptions to medical improvement described in (f) or (g) applies.

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

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

(4) *Do you have a severe impairment or combination of impairments?* If there has been medical improvement in your impairment(s) related to the ability to work, or if one of the first group of exceptions applies, we will determine whether your current impairment(s) is severe, as defined in § 416.924(d). If your impairment(s) is not severe, we will find that your disability has ended. If your impairment(s) is severe, we will proceed to the last step.

(5) *Are you currently disabled?* In connection with our determination that there has been medical improvement in your impairment(s) related to the ability to work, or if one of the first group of exceptions applies, and you have a severe impairment or combination of impairments, we will do an individualized functional assessment of the impact of your impairment(s) on your overall ability to function independently, appropriately, and effectively in an age-appropriate manner. (See § 416.924a.) We will use this individualized functional assessment to decide whether you are currently disabled; that is, whether you have an impairment(s) of comparable severity to an impairment that would prevent an adult from engaging in substantial gainful activity. We will apply the rules and guidelines governing the last step of the childhood sequential evaluation process for initial claims in § § 416.924 through 416.924e. If you are currently disabled, your eligibility will continue. If you are not currently disabled, your eligibility for disability benefits will end.

(c) *What we mean by medical improvement.* Medical improvement is any decrease in the medical severity of your impairment(s) which was present at the time of the most recent favorable decision that you were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on changes (improvement) in the symptoms, signs, or laboratory findings associated with your impairment(s).

(1) The most recent favorable decision is the latest final determination or decision involving a consideration of the medical evidence and whether you were disabled or continued to be disabled.

(2) The terms "symptoms," "signs," and "laboratory findings" are defined in § 416.928. For children, our definitions of the terms "symptoms," "signs," and "laboratory findings" may include any abnormalities of physical and mental functioning that we used in making our most recent favorable decision.

(3) Some impairments are subject to temporary remissions, which can give the appearance of medical improvement when in fact there has been none. If you have the kind of impairment that is subject to temporary remissions, we will be careful to consider the longitudinal history of the impairment, including the occurrence of prior remissions and prospects for future worsenings, when we decide whether there has been medical improvement. Improvements that are only temporary will not warrant a finding of medical improvement.

(4) If we find that there has been improvement in your symptoms, signs, or laboratory findings, we will find that medical improvement has occurred and proceed to determine whether the medical improvement is related to your ability to work.

(d) *What we mean by medical improvement related to the ability to work.* For a child, we say that medical improvement is related to the ability to work when there has been an increase in the ability to function independently, appropriately, and effectively in an age-appropriate manner. Hence, if your impairment(s) has medically improved as defined in (c), but your ability to function in an age-appropriate manner has not increased, we will find that your medical improvement is not related to your ability to work. A determination that there has been medical improvement related to your ability to work does not necessarily mean that we will find that your disability has ended. We must also show that your are not currently disabled using rules governing severity and the last step of the childhood sequential evaluation process for initial claims in § § 416.924 through 416.924e. We determine whether medical improvement is related to the ability to work as follows:

(1) *Previous decision based on a finding that your impairment(s) met or equaled a listing.* (i) We do not consider whether your impairment(s) has medically improved until we have decided that you do not have an impairment(s) that meets or equals a current listing. If our most recent favorable decision was based on a finding that your impairment(s) met or equaled in severity a listing that is in our current Listing of Impairments and your impairment(s) no longer meets or equals that listing, we will find at this step that your medical improvement was related to your ability to work. We will do an individualized functional assessment and proceed to determine whether you are currently disabled or whether one of the exceptions applies, as set forth in paragraph (b)(5) of this section.

(ii) If our most recent favorable decision was based on a finding that your impairment(s) met or equaled a listing that is no longer in the Listing of Impairments or that has since been revised, we will consider whether your impairment(s) continues to meet or equal that prior listing at this step. If your impairment(s) continues to meet or equal the prior listing, we will find that your disability continues, even though your impairment(s) does not meet or equal any current listing. If your impairment does not meet or equal the prior listing, we will find that your medical improvement was related to your ability to work. We will do an individualized functional assessment and proceed to determine whether you are currently disabled or whether one of the exceptions applies, as set forth in paragraph (b)(5) of this section.

(2) *Previous decision based on an individualized functional assessment.* If our most recent favorable decision was based on an individualized functional assessment, we will do a new individualized functional assessment based on the previously existing impairments. However, the new individualized functional assessment will be based on those functions that are appropriate to your current age.

(i) We will use this assessment to determine whether there has been an increase in your ability to function in an age-appropriate manner since our most recent favorable decision by comparing our current assessment with the assessment we made at the time of the most recent favorable decision.

(ii) We will not generally do a new individualized functional assessment for the time of the most recent favorable decision; we will use the assessment we made at the time of the last decision. However, if the most recent favorable decision was based on an individualized functional assessment and we do not have that assessment (for example, because it is missing from your file), we will have to reconstruct the assessment. We will do this by assuming that you had the maximum functional abilities consistent with a decision of allowance or continuance at the time of the most recent favorable decision.

(iii) If there has been improvement in your age-appropriate functioning, we

will find that your medical improvement is related to the ability to work, and proceed to determine whether you are currently disabled or whether one of the exceptions applies, as set forth in paragraph (b)(5) of this section.

(e) *Prior file cannot be located.* If we cannot locate your prior file, we will first determine whether you are currently disabled under the sequence set forth in § 416.924. (In this way, we will determine that your benefits continue at the earliest time without reconstructing prior evidence.) If so, your benefits will continue unless one of the second group of exceptions applies (see paragraph (g) of this section). If not, we will determine whether an attempt should be made to reconstruct those portions of the missing file that were relevant to our most recent favorable decision (e.g., school records, medical evidence from treating sources, and the results of consultative examinations). This determination will consider the potential availability of old records in light of their age, whether the source of the evidence is still in operation, and whether reconstruction efforts will yield a complete record of the basis for the most recent favorable decision. If relevant parts of the prior record are not reconstructed, either because we decide not to attempt reconstruction or because our efforts failed, we will not find that you have medically improved. The documentation of your current impairment(s) will provide a basis for any future reviews. If the missing file is later found, it may serve as a basis for reopening any determination or decision under this section, in accordance with § 416.1488.

(f) *First group of exceptions to medical improvement.* The law provides certain limited situations when your disability can be found to have ended even though medical improvement has not occurred, if your impairment(s) is no longer of comparable severity to any impairment(s) that would make an adult disabled. These exceptions to medical improvement are intended to provide a way of finding that a person is no longer disabled in those limited situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the person should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, we must also show that your impairment(s) is now no longer of comparable severity to any impairment(s) that would disable an adult before we can find you are no longer disabled, taking all your current impairments into account, not just those that existed at the time of our most recent favorable decision. As part of the review process, you will be asked about any medical or vocational therapy you received or are receiving. Your answers and the evidence gathered as a result, as well as all other evidence, will serve as the basis for the finding that an exception applies.

(1) *Substantial evidence shows that you are the beneficiary of advances in medical or vocational therapy or technology (related to your ability to work).* Advances in medical or vocational therapy or technology are improvements in treatment or rehabilitative methods which have reduced the severity of your impairment(s). We will apply this exception when substantial evidence shows that you have been the beneficiary of services which reflect these advances and they have favorably affected the severity of your impairment or your ability to function in an age-appropriate manner. This decision will be based on new medical evidence and a new individualized functional assessment. (See § 416.924a.) This exception does not apply if you are eligible to receive special Supplemental Security Income cash benefits, as explained in § 416.261. In many instances, an advanced medical therapy or technology will result in a decrease in severity as shown by symptoms, signs, and laboratory findings which will meet the definition of medical improvement. This exception should, therefore, have limited application.

(2) *Substantial evidence shows that you have undergone vocational therapy (related to your ability to work).* Vocational therapy (related to your ability to work) may include, but is not limited to, education, training, or work experience that improves your ability to meet the vocational requirements of jobs. This decision will be based on substantial evidence which includes new medical evidence and a new individualized functional assessment. (See § 416.924a.) This exception does not apply if you are eligible to receive special Supplemental Security Income cash benefits, as explained in § 416.261. If at the time of our review, you have not completed vocational therapy which could affect the continuance of your disability, we will review your claim upon completion of the therapy.

(3) *Substantial evidence shows that, based on new or improved diagnostic or evaluative techniques, your impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.* Changing methodologies and advances in medical and other diagnostic or evaluative techniques have given rise to, and will continue to give rise to, improved methods for determining the causes of (i.e., diagnosing) and measuring and documenting the effects of various impairments on children and their functioning. Where, by such new or improved methods, substantial evidence shows that your impairment(s) is not as severe as was determined at the time of our most recent favorable decision, such evidence may serve as a basis for a finding that you are no longer disabled, provided that you do not currently have an impairment(s) that is of comparable severity to an impairment(s) that would disable an adult. In order to be used under this exception, however, the new or improved techniques must have become generally available after the date of our most recent favorable decision.

(i) *How we will determine which methods are new or improved techniques and when they become generally available.* New or improved diagnostic techniques or evaluations will come to our attention by several methods. In reviewing cases, we often become aware of new techniques when their results are presented as evidence. Such techniques and evaluations are also discussed and acknowledged in medical literature by medical professional groups and other governmental entities. Through these sources, we develop listings of new techniques and when they become generally available. For example, we will consult the Health Care Financing Administration for its experience regarding when a technique is recognized for payment under Medicare and when they began paying for the technique.

(ii) *How you will know which methods are new or improved techniques and when they become generally available.* We will let you know which methods we consider to be new or improved techniques and when they become available through two vehicles.

(A) Some of the future changes in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter will be based on new or improved diagnostic or evaluative techniques. Such listings changes will clearly state this fact as they are published as Notices of Proposed Rulemaking and the new or improved technique will be considered generally available as of the date of the final publication of that particular listing in the **Federal Register**.

(B) From time to time, we will publish in the **Federal Register** cumulative lists

of new or approved diagnostic techniques or evaluations that have been in use since 1970, how they changed the evaluation of the applicable impairment and the month and year they became generally available. We will include any changes in the Listing of Impairments published in the Code of Federal Regulations since 1970 that are reflective of new or improved techniques. We will not process any cases under this exception using a new or improved diagnostic technique that we have not included in a published notice until we have published an updated cumulative list. The period between publications will be determined by the volume of changes needed.

(4) *Substantial evidence demonstrates that any prior disability decision was in error.* We will apply the exception to medical improvement based on error if substantial evidence (which may be evidence on the record at the time any prior determination or decision of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination or decision) demonstrates that a prior determination or decision (of allowance or continuance) was in error. A prior determination or decision will be found in error only if:

(i) Substantial evidence shows on its face that the determination or decision in question should not have been made (e.g., the evidence in your file, such as pulmonary function study values, was misread, or an adjudicative standard, such as a listing appendix 1 of subpart P of part 404 of this chapter, was misapplied).

(ii) At the time of the prior evaluation, required and material evidence of the severity of your impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that, had such evidence been present at the time of the prior determination or decision, disability would not have been found.

(iii) New substantial evidence that relates to the prior determination or decision refutes the conclusions that were based upon the prior evidence at the time of that determination or decision (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that, had the new evidence (which relates to the prior determination or decision) been considered at the time of the prior determination or decision, the claim would not have been allowed or continued. A substitution of current judgment for that used in the prior favorable determination or decision will not be the basis for applying this exception.

(iv) The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision (see §§ 416.1488 and 416.1489) are met.

(g) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination or decision that you are no longer disabled. In these situations, the determination or decision will be made without a finding that you have demonstrated medical improvement related to the ability to work or that you are currently not disabled under the rules in §§ 416.924 through 416.924e. There is no set point in the continuing disability review sequence described in paragraph (b) of this section at which we must consider these exceptions; exceptions in the second group may be considered at any point in the process.

(1) *A prior determination or decision was fraudulently obtained.* If we find that any prior favorable determination or decision was obtained by fraud, we may find that you are not disabled. In addition, we may reopen your claim under the rules in § 416.1488.

(2) *You do not cooperate with us.* If there is a question about whether you continue to be disabled and we ask you to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 416.1411 discusses how we will decide whether you have good cause for failure to cooperate. In addition, § 416.918 discusses how we decide whether you have good cause for failing to attend a consultative examination. The month in which your disability ends will be the first month in which you failed to do what we asked.

(3) *We are unable to find you.* If there is a question about whether you continue to be disabled and we are unable to find you to resolve the question, we will suspend your payments. The month your payments are suspended will be the first month in which the question arose and we could not find you.

(4) *You fail to follow prescribed treatment which would be expected to restore your ability to function independently, appropriately, and effectively in an age-appropriate manner.* If treatment has been prescribed for you which would be expected to restore your ability to function independently, appropriately, and effectively in an age-appropriate manner, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have good cause for failing to follow that treatment, we will find that your disability has ended (see § 416.930(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

(h) *The month in which we will find you are no longer disabled.* If the evidence shows that you are no longer disabled, we will find that your disability ended in the following month—

(1) The month the evidence shows that you are no longer disabled under the rules set out in this section, and you were disabled only for a specified period of time in the past;

(2) The month the evidence shows that you are no longer disabled under the rules set out in this section, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not disabled;

(3) The month in which you return to, or begin, full-time work with no significant medical restrictions, and acknowledge that medical improvement has occurred, and we expected your impairment(s) to improve (see § 416.991);

(4) The first month in which you fail without good cause to follow prescribed treatment, when the rule set out in paragraph (g)(4) of this section applies;

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

(6) The first month in which you failed without good cause to do what we asked, when the rule set out in paragraph (g)(2) of this section applies.

(i) *Before we stop your benefits.* If we find you are no longer disabled, before we stop your benefits, we will give you a chance to explain why we should not do so. Subparts M and N of this part describe your rights and the procedures we will follow.

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