



# Federal Register

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**Thursday,  
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**Part II**

## **Social Security Administration**

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**20 CFR Parts 404 and 416  
Revised Medical Criteria for Evaluating  
Mental Disorders; Proposed Rule**

**SOCIAL SECURITY ADMINISTRATION****20 CFR Parts 404 and 416**

[Docket No. SSA-2007-0101]

RIN 0960-AF69

**Revised Medical Criteria for Evaluating Mental Disorders****AGENCY:** Social Security Administration.**ACTION:** Notice of proposed rulemaking (NPRM).

**SUMMARY:** We propose to revise the criteria in the Listing of Impairments (listings) that we use to evaluate claims involving mental disorders in adults and children under titles II and XVI of the Social Security Act (Act). We also propose to remove certain sections of our regulations and incorporate some of their provisions into other sections of our regulations. The proposed revisions reflect our adjudicative experience, advances in medical knowledge, recommendations from a report we commissioned, and comments we received from experts and the public in response to an advance notice of proposed rulemaking (ANPRM) and at an outreach policy conference.

**DATES:** To ensure that your comments are considered, we must receive them no later than November 17, 2010.

**ADDRESSES:** You may submit comments by any one of three methods—Internet, fax, mail. Do not submit the same comments multiple times or by more than one method. Regardless of which method you choose, please state that your comments refer to Docket No. SSA-2007-0101 so that we may associate your comments with the correct regulation.

*Caution:* You should be careful to include in your comments only information that you wish to make publicly available. We strongly urge you not to include in your comments any personal information, such as Social Security numbers or medical information.

- *Internet:* We strongly recommend that you submit your comments via the Internet. Please visit the Federal eRulemaking portal at <http://www.regulations.gov>. Use the Search function to find docket number SSA-2007-0101. The system will issue a tracking number to confirm your submission. You will not be able to view your comment immediately because we must post each comment manually. It may take up to a week for your comment to be viewable.

- *Fax:* Fax comments to (410) 966-2830.

- *Mail:* Address your comments to the Office of Regulations, Social Security Administration, 137 Altmeyer Building, 6401 Security Boulevard, Baltimore, Maryland 21235-6401.

Comments are available for public viewing on the Federal eRulemaking portal at <http://www.regulations.gov> or in person, during regular business hours, by arranging with the contact person identified below.

**FOR FURTHER INFORMATION CONTACT:** Cheryl A. Williams, Office of Medical Listings Improvement, Social Security Administration, 6401 Security Boulevard, Baltimore, Maryland 21235-6401, (410) 965-1020. For information on eligibility or filing for benefits, call our national toll-free number, 1-800-772-1213, or TTY 1-800-325-0778, or visit our Internet site, Social Security Online, at <http://www.socialsecurity.gov>.

**SUPPLEMENTARY INFORMATION:****Electronic Version**

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

**Why are we proposing to revise the listings for mental disorders?**

We have not comprehensively revised section 12.00 of the listings—the mental disorders body system for adults (persons who are at least 18 years old)—since we published it in the **Federal Register** on August 28, 1985.<sup>1</sup> We last published final rules that comprehensively revised section 112.00—the mental disorders listings for children (persons under age 18)—on December 12, 1990.<sup>2</sup>

Although the 1985 and 1990 listings were significant advancements in our rules at the time we published them, they were based in part on prior editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM).<sup>3</sup> We have also gained considerable adjudicative experience in the decades since we published those adult and child listings.

We published some updates to the mental disorders listings in 2000. Those updates improved the rules, but did not comprehensively revise or update them.<sup>4</sup>

<sup>1</sup> 50 FR 35038 (1985).

<sup>2</sup> 55 FR 51208 (1990).

<sup>3</sup> The 1985 adult listings were based in part on the third edition of the DSM (the DSM-III), and the 1990 childhood listings were based in part on the revised third edition (the DSM-III-R).

<sup>4</sup> On July 18, 1991, we published an NPRM and proposed to update and revise many of the rules for

We are now proposing to update and revise the listings for mental disorders to reflect our adjudicative experience and the advances in medical knowledge, treatment, and methods of evaluating mental disorders that have occurred since we last revised them comprehensively. As we explain below, the proposed rules also reflect recommendations from a report we commissioned, comments we received in response to an ANPRM, and information from a policy conference we held about mental disorders in the disability programs.

**How did we develop these proposed rules?**

In addition to our adjudicative experience and review of advances in medical knowledge, treatment, and methods of evaluating mental disorders, we asked experts and the public to provide us with information that helped us develop the proposals.

1. In 2000, we commissioned a report from the National Research Council (NRC), *Mental Retardation: Determining Eligibility for Social Security Benefits* (NRC report), published in 2000.<sup>5</sup> The primary focus of the report was on persons who have mental retardation in what is called the “mild” range in the current edition of the DSM, the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR);<sup>6</sup> that is, with intelligence quotient (IQ) scores from 50–55 to approximately 70. The NRC committee:

- Examined the scientific bases regarding intelligence and adaptive behavior, the relationship between them, and the assessment of both;
- Examined differential diagnosis; and
- Searched the related literature.

2. We published an ANPRM in the **Federal Register** on March 17, 2003.<sup>7</sup> We informed the public that we were planning to update and revise the rules

adults that we published in 1985 and some of the childhood rules that we published in 1990; we also proposed in §§ 404.1520a and 416.920a new rules for evaluating mental disorders in children. 56 FR 33130. On August 21, 2000, we published final rules for only some of the provisions we proposed in the NPRM. 65 FR 50746, corrected at 65 FR 60584. We explained in the preamble to that notice that medical changes and changes in the law since the time we published the NPRM required us to review some of our proposed revisions and to defer action on those proposed revisions. We also published minor revisions to the childhood mental disorders listings on February 11, 1997, and September 11, 2000, because of changes in the law. 62 FR 6408 and 65 FR 54747.

<sup>5</sup> Citation in the References section at the end of this preamble.

<sup>6</sup> Complete citation in the References section of this preamble.

<sup>7</sup> 68 FR 12639 (2003).

we use to evaluate mental disorders and invited interested persons and organizations to send us comments and suggestions for updating and revising the mental disorders listings. We also asked for comments on the NRC report.<sup>8</sup> We received almost 500 letters and e-mails in response to the notice, many from persons who have mental disorders or who have family members with such disorders. We also received comments from medical experts, advocates, and our adjudicators.<sup>9</sup>

3. We hosted a policy conference called "Mental Disorders in the Disability Programs" in Washington, DC, on September 23 and 24, 2003. At this conference, we received comments and suggestions for updating and revising our rules from physicians who treat patients with mental disorders, other professionals and advocates who work with persons who have mental disorders, and adjudicators who make disability determinations and decisions for us in the State agencies and in our Office of Disability Adjudication and Review.

Although we are not summarizing or formally responding to most of the comments we received, many of the changes we propose reflect those comments.

### How are the current mental disorders listings structured, and what do they require?

For most of the listed mental disorders, the current listings are in three, or sometimes four, parts.<sup>10</sup> The first part of every mental disorder listing is a brief introductory paragraph that provides a general diagnostic description of the disorder(s) covered by the listing. The second part of most of these listings contains "paragraph A" criteria, which are the specific symptoms, signs, and laboratory findings that substantiate the presence of particular mental disorders. An impairment cannot meet a mental disorder listing unless it satisfies the diagnostic description and the paragraph A criteria of that listing. The third part of most mental disorder listings contains "paragraph B" criteria, which for adults describe impairment-related functional limitations that are

incompatible with the ability to work.<sup>11</sup> The paragraph B criteria provide descriptions of the four areas of functioning that we use to establish the severity of a person's mental disorder. A mental disorder is of listing-level severity if it satisfies two of the paragraph B criteria.<sup>12</sup>

Some listings<sup>13</sup> also include a fourth part, which we call "paragraph C" criteria. The paragraph C criteria are alternatives to paragraph B for establishing the severity of certain chronic mental disorders. In the paragraph C criteria, we recognize that psychosocial supports, treatment, or both may control the more obvious symptoms and signs of a chronic mental disorder, so that a person may not appear to be as limited as he or she actually is. The paragraph C criteria provide a way for finding listing-level disability in persons whose impairments do not meet the current paragraph B criteria, but who cannot tolerate the stress of work.

### What major revisions are we proposing?

We propose to revise both the content and the structure of the adult and childhood mental disorders listings. The proposed mental disorders listings do not include an introductory diagnostic paragraph or a set of specific paragraph A diagnostic criteria. Instead, a person would need only show that he or she has a mental disorder that:

- (1) Is covered by one of the ten listing categories, and
- (2) Except for certain listings under 12.05, results in marked limitations of two or extreme limitation of one of four paragraph B "mental abilities" or satisfies the paragraph C criteria.

We are also proposing to:

- Broaden most of the current listing categories to include more mental disorders.
- Add listings.
- Provide new paragraph B criteria.
- Revise the paragraph C criteria and extend them to all of the mental

disorders listing categories except proposed listings 12.05 and 12.05.

- Clarify our definitions of the terms "marked" and "extreme."

As we have already noted, some of the proposed revisions reflect comments and recommendations we received from persons who responded to the ANPRM and from others who attended the 2003 conference. Some of the proposed revisions based on comments and recommendations include:

Some commenters recommended that we include all mental disorders described in the most recent version of the DSM. We agreed with the commenters that the listings should include more mental disorders than they do now, but we did not agree that we should include all mental disorders. Some mental disorders are unlikely to result in functional limitations of listing-level severity or meet the duration requirement, and some are otherwise inappropriate for inclusion in our listings. Instead, we propose to broaden most of the current listing categories and to add some new listings.

The proposed new paragraph B criteria reflect comments from several mental health advocates who recommended that we provide criteria for evaluating a person's functioning in work-related terms. These advocates thought that we should: (1) Look at the impact of an impairment across domains of functioning critical for an adult to function in competitive employment, (2) create criteria that reflect a person's lack of skills in managing life and work, and (3) consider whether the person has the capacity to exercise independent judgment and truly care for himself or herself in a meaningful way without structure. We would also use the same criteria for children beginning at age 3, although in terms appropriate to childhood functioning.<sup>14</sup>

We also agreed with several commenters who recommended that we add a criterion for "extreme" limitation in paragraph B, so that a person's mental disorder can meet a listing with either "extreme" limitation in only one of the paragraph B criteria or "marked" limitation in two. We already have such criteria for children from birth to age 3 in the current listings, but not for older children or adults. We agreed with commenters who suggested that we use

<sup>11</sup> At the end of this preamble, we provide information about two projects we have underway that may help us to better identify the requirements of work in the future. While the outcome of these projects may affect rules that we may propose in the future, we believe that these long-term projects do not affect our decision to proceed with these proposed rules now.

<sup>12</sup> We use different paragraph B criteria in the childhood listings to describe functional limitations in children of varying ages.

<sup>13</sup> Adult listings 12.02, 12.03, 12.04, and 12.06. There are no current childhood mental disorders listings with paragraph C criteria, but we can use the adult paragraph C criteria in appropriate child cases. See the seventh paragraph of current 12.00A.

<sup>14</sup> For children under age 3, we are proposing to add a new listing with paragraph B criteria that largely reflect the same mental abilities that we propose in the paragraph B criteria for children beginning at age 3 and for adults, but in terms appropriate for children in this age group. Thus, we would establish a fairly seamless continuum of evaluation from birth into adulthood.

<sup>8</sup> 68 FR at 12640.

<sup>9</sup> If you would like to read the comments, you can find them on our Internet site at: <https://s044a90.ssa.gov/apps10/erm/rules.nsf/Rules+Closed+To+Comment>. Click on the link for "0960-AF69: Revised Medical Criteria for Evaluating Mental Disorders."

<sup>10</sup> In the adult listings, the exceptions are listings 12.05 (mental retardation) and 12.09 (substance addiction disorders).

the definitions of “marked” and “extreme” limitations that are in Supplemental Security Income (SSI) childhood disability regulations that we had recently issued.

We are also proposing to revise the paragraph C criteria based in part on comments that our current requirement for a medically documented 2-year history is unclear given the 1-year duration requirement in the definition of disability. We also agreed with commenters who recommended that we change the criterion in paragraph C for “decompensation” to “deterioration” because the former term is not appropriate in all cases. It refers to a state of extreme deterioration, often leading to hospitalization. We also agreed with a recommendation to add paragraph C criteria to the other mental disorders listings since the criteria could apply to other types of mental disorders. The only exception is under listings 12.05 and 112.05, where we do not believe it is necessary.

Finally, we agreed with a recommendation to expand and clarify our rules to recognize that non-physician professional sources, such as therapists and social workers, are often the mental health providers who can best provide a person’s history and longitudinal evidence about

functioning; that is, the person’s functioning over time. The commenters noted that such a change would realistically reflect the way that mental health care is provided to most persons with chronic mental impairments.

**What other significant revisions are we proposing?**

We also propose to:

- Remove §§ 404.1520a and 416.920a, Evaluation of Mental Impairments. However, we would incorporate some of the provisions of these rules into other sections of our regulations.

- Expand, update, and reorganize the introductory text of the listings.
- Change the term “Mental Retardation” to “Intellectual Disability/Mental Retardation (ID/MR).”

- Remove listings 12.09, Substance Addiction Disorders, and 112.09, Psychoactive Substance Dependence Disorders.

- Revise the heading of listing 112.11 from “Attention Deficit Hyperactivity Disorder” to “Other Disorders Usually First Diagnosed in Childhood or Adolescence.” This proposed listing would still include attention-deficit/hyperactivity disorder, but would also include tic disorders, now in current listing 112.07 (Somatoform, Eating, and Tic Disorders), and other mental

disorders we do not currently list. We would also add listing 12.11 to cover these disorders in adults.

- Add a separate listing 112.13 for eating disorders in children, now covered by listing 112.07, and listing 12.13 to cover these disorders in adults.

- Add listing 112.14, Developmental Disorders of Infants and Toddlers (Birth to Attainment of Age 3), and remove current listing 112.12, Developmental and Emotional Disorders of Newborn and Younger Infants (Birth to attainment of age 1).

**Proposed 12.00—Introductory Text to the Adult Mental Disorders Listings**

The following is a detailed description of the changes we are proposing to the introductory text.

**Proposed 12.00A—What are the mental disorders listings, and what do they require?**

*Proposed 12.00A1*

In this section, we name the ten proposed listing categories. These categories generally reflect major diagnostic categories in the DSM–IV–TR. We propose to change the names of six current listing categories, to remove a listing, and to add two listings, as shown in the table below.

Current listing category	Proposed listing category
12.02 Organic Mental Disorders	12.02 Dementia and Amnesic and Other Cognitive Disorders.
12.03 Schizophrenic, Paranoid and Other Psychotic Disorders	12.03 Schizophrenia and Other Psychotic Disorders.
12.04 Affective Disorders	12.04 Mood Disorders.
12.05 Mental Retardation	12.05 Intellectual Disability/Mental Retardation (ID/MR).
12.06 Anxiety Related Disorders	12.06 Anxiety Disorders.
12.07 Somatoform Disorders	12.07 Somatoform Disorders.
12.08 Personality Disorders	12.08 Personality Disorders.
12.09 Substance Addiction Disorders	[Removed—see proposed 12.00H].
12.10 Autistic Disorder and Other Pervasive Developmental Disorders	12.10 Autism Spectrum Disorders.
	12.11 Other Disorders Usually First Diagnosed in Childhood or Adolescence.
	12.13 Eating Disorders.

*Proposed 12.00A2*

In this section, we explain the structure of the mental disorders listings and how a person’s impairment can meet a listing. The standard for meeting a listing based on “marked” limitations of two of the paragraph B mental abilities is the same as in the current mental disorders listings. The standard for meeting a listing based on “extreme” limitation of one mental ability would be new in the listings. Under current §§ 404.1520a(c)(4) and 416.920a(c)(4), however, a mental disorder that results in “extreme” limitation medically equals a listing. Under these rules, “extreme” limitation “represents a degree of limitation that is incompatible with the

ability to do any gainful activity,” which other rules explain is the standard of severity in the listings. Sections 404.1525(a) and 416.925(a). For this reason, our proposal to add a criterion for “extreme” limitation in the mental disorder listings would simplify our rules, allowing for a finding that an impairment meets, rather than equals, a listing.

In paragraph A2b(ii) of this section, we explain that, whenever we use the phrase “the paragraph B criteria” or “paragraph B” in the introductory text, we mean the paragraph B criteria of every mental disorder listing except listing 12.05. We are including this statement because listing 12.05 also has

a paragraph B, but it is somewhat different from the “paragraph B” criteria common to all of the other listings. We include a similar statement regarding the paragraph C criteria in proposed 12.00A2c, where we briefly explain those criteria.

*Proposed 12.00A3*

In this section, we explain how a person’s ID/MR meets proposed listing 12.05.

**Proposed 12.00B—How do we describe the mental disorders listing categories?**

In this new section, we describe the listing categories we use in the mental disorders listings. We then provide examples of symptoms and signs that

persons with disorders in each category may have. We also give examples of specific mental disorders in each category except listing 12.05, which covers only ID/MR. The information in the description of each category is not all-inclusive. We provide only basic information about some of the most commonly occurring mental disorders as examples of the kinds of disorders that we evaluate under each listing category.

The descriptions in 12.00B are similar to the current introductory diagnostic paragraphs and the paragraph A criteria, but we are not simply moving the introductory diagnostic paragraphs and the current paragraph A criteria from the listings into the introductory text. While the evidence must show that the person has a mental disorder in one of the listing categories, the mental disorder does not have to match one of the examples in proposed 12.00B. We will find that any mental disorder meets one of these listings when it can be included in one of the listings categories and satisfies the other criteria of the appropriate listing for that mental disorder.

The sections of proposed 12.00B do not require explanation, except for proposed 12.00B1 and 12.00B4.

*Proposed 12.00B1—Dementia and Amnestic and Other Cognitive Disorders (12.02)*

In the DSM-IV-TR, this category is called “Delirium, dementia, and amnestic and other cognitive disorders.” We do not include the term “delirium” because delirium will generally not meet the 12-month duration requirement.

In proposed 12.00B1c, we include traumatic brain injury (TBI) as an example of a mental disorder we can evaluate under proposed listing 12.02. We continue to include a reference to 11.00F in the neurological section of our listings, as we do in current 12.00D10, to ensure that our adjudicators give full consideration to both the neurological and mental limitations resulting from TBI.

*Proposed 12.00B4—Intellectual Disability/Mental Retardation (ID/MR) (12.05)*

### Proposed Name Change

As we noted earlier, we propose to change the name “Mental Retardation” to “Intellectual Disability/Mental Retardation (ID/MR).” The term “mental retardation” has taken on negative connotations over the years, is offensive to many persons, and results in misunderstandings about the nature of

the disorder and the persons who have it. The term “intellectual disability” is now widely used internationally and is gradually replacing “mental retardation” in the United States.

For these reasons, and consistent with many other organizations, we are proposing to introduce the term “intellectual disability” in these listings.<sup>15</sup> Even though “mental retardation” is offensive to many persons, we are not proposing to remove it from our listings at this time; rather, we refer to “intellectual disability” and “mental retardation” together as the same disorder.<sup>16</sup> We have a number of reasons for doing this, including the following:

- Although the term “mental retardation” is gradually being replaced in the United States, it is still widely used and familiar to most persons.
- The DSM-IV-TR and some other leading clinical practice manuals still use the term.
- Many medical reports, school records, and other documents that are included in case files contain the term.
- A number of Federal and State benefit programs still use the term.

Also, since we recognize that not everyone in the United States is familiar with the term “intellectual disability,” we want to be clear in these rules that we evaluate only what some persons still call “mental retardation” under listing 12.05 and not other forms of cognitive impairments, such as learning disorders (which we would evaluate under proposed listing 12.11).

### Proposal To Require “Significant” Deficits in Adaptive Functioning To Demonstrate ID/MR

The introductory diagnostic paragraph in current listing 12.05 does not describe a level of severity for deficits of adaptive functioning. In proposed 12.00B4a, which describes the characteristics of ID/MR, we would require “significant” deficits of adaptive functioning. Major associations that provide diagnostic criteria for mental retardation generally refer to “significant” deficits or limitation.

The most recent edition of the American Association on Intellectual and Developmental Disabilities (AAIDD) manual states:

<sup>15</sup> For more information about the use of new terms to replace “mental retardation,” please refer to the 2002 report, “Usage of the Term ‘Mental Retardation’: Language, Image and Public Education,” available on our Web site at <http://www.socialsecurity.gov/disability/MentalRetardationReport.pdf>. Complete citation in the References section of this preamble.

<sup>16</sup> We are also proposing to introduce the abbreviation “ID/MR,” so we will not be using the phrase “mental retardation” as often as we do now.

*For the diagnosis of intellectual disability, significant limitations in adaptive behavior should be established through the use of standardized measures normed on the general population, including people with disabilities and people without disabilities. On these standardized measures, significant limitations in adaptive behavior are operationally defined as performance that is approximately 2 standard deviations below the mean of either (a) one of the following three types of adaptive behavior: conceptual, social, or practical, or (b) an overall score on a standardized measure of conceptual, social, and practical skills. \* \* \* 17*

The American Psychological Association’s *Manual of Diagnosis and Professional Practice in Mental Retardation* states:

Significant limitations in adaptive functioning are determined from the findings of assessment by using a comprehensive, individual measure of adaptive behavior. For adaptive behavior measures, the criterion of significance is a summary index score that is two or more standard deviations below the mean for the appropriate norming sample or that is within the range of adaptive behavior associated with the obtained IQ range sample in the instrument norms. \* \* \* For adaptive behavior measures that provide factor or summary scores, the criterion of significance is multidimensional; that is, two or more of these scores lie two or more standard deviations below the mean for the appropriate norming sample or lie within the range of adaptive behavior associated with the intellectual level consistent with the obtained intelligence quotient, as indicated by the instrument norms.<sup>18</sup>

The DSM-IV-TR states:

The essential feature of mental retardation is significantly subaverage intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skills areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B).<sup>19</sup>

Therefore, the proposed requirement for “significant” deficits in adaptive functioning is generally consistent with the diagnostic criteria used in the clinical community.

### Proposed Clarification of Our Rule on the Developmental Period for ID/MR

In the introductory paragraph of listing 12.05, we explain that a person’s

<sup>17</sup> American Association on Intellectual and Developmental Disabilities, *Intellectual Disability: Definition, Classification, and Systems of Supports, 11th Edition*, Washington, DC (2010), page 43.

<sup>18</sup> Jacobson, John W., and Mulick, James A., eds., *Manual of Diagnosis and Professional Practice in Mental Retardation*, American Psychological Association, Washington, DC (1996), page 13.

<sup>19</sup> American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, (DSM-IV-TR)*, Washington, DC (2000), page 41.

mental retardation must be manifested during the “developmental period; [that is,] \* \* \* before age 22.” We propose to simplify this language by removing our reference to the “developmental period” and referring only to the period before age 22. The proposed change would not be substantive since the phrase “developmental period” means the period before the person attained age 22.

Also, in proposed 12.00B4c, we explain that ID/MR initially manifested before age 22 is often demonstrated by evidence from that period, but that, when we do not have such evidence, we will still find that a person has ID/MR if the current evidence and the history of the impairment are consistent with the diagnosis “and there is no evidence to indicate an onset after age 22.” The quoted language is a clarification of our rules. In the current introductory paragraph of listing 12.05, we provide that the evidence must demonstrate “or support[ ]” onset of the impairment before age 22. We added this language in 2000 to better explain what we mean by evidence demonstrating that the disorder was initially manifested before age 22,<sup>20</sup> but we have received questions indicating that our intent is still not clear. Therefore, we are proposing to clarify the provision even further.

In proposed 12.00B4d, we would continue to include our rule that we accept the lowest IQ score on a test that provides more than one score (for example, a verbal, performance, and full scale IQ in a Wechsler series test). For a number of reasons, the NRC recommended that we change our rule to consider only the composite or “total” score (such as full scale IQ).<sup>21</sup> We decided not to propose the change at this time because we believe it is unnecessary and keeping our current rule will help us to adjudicate some cases more quickly than we would if we accepted the NRC recommendation. We are putting more emphasis in these rules on the need to confirm the validity of test results with other evidence, especially of a person’s day-to-day functioning. We are also clarifying that a person must have “significant” deficits

of adaptive functioning. The approach in these proposed rules is more in keeping with modern definitions of ID/MR, especially in the 2010 edition of the AAIDD manual, which emphasizes the “multidimensional” aspects of defining ID/MR.<sup>22</sup> We also know from our case reviews that only a relatively few claimants who qualify under current listing 12.05 do not have ID/MR, and we believe that the improvements we are making in these proposed rules will make our determinations and decisions even more accurate. Thus, we believe that, properly applied, the proposed rules will correctly identify persons who have the disorder.

In proposed 12.00B4e, we would clarify a number of provisions about listing 12.05C:

- We explain that the other physical or mental impairment must be a “severe” impairment, as defined in our regulations. We also explain that we do not count impairments that are not “severe” even if they prevent a person from doing past relevant work. Both of these provisions are in the fourth paragraph of current 12.00A.

- Current listing 12.05C provides that the other impairment must “impos[e] an *additional* and significant work-related limitation of functioning.” (Emphasis added.) We propose to clarify this provision by specifying that the limitation(s) caused by the other physical or mental impairment must be separate from the limitations caused by the ID/MR.

*Proposed 12.00C—What are the paragraph B criteria?*

In this section, we describe the four paragraph B criteria that we propose to use to assess a person’s impairment-related limitation in functioning in the mental disorder listings. The proposed paragraph B criteria are the mental abilities an adult uses to function in a work setting; that is, the abilities to:

- Understand, remember, and apply information (paragraph B1);
- Interact with others (paragraph B2);
- Concentrate, persist, and maintain pace (paragraph B3); and
- Manage oneself (paragraph B4).

We based the proposed criteria in part on critical work-related limitations and abilities that we consider at other steps in the five-step sequential evaluation process that we use to determine disability in adults. We also propose to use an approach for evaluating limitations similar to the approach we use in determining functional equivalence for children under SSI. We

would consider how a mental disorder affects the person’s underlying mental abilities and, thus, results in limitations in functioning. In addition, we have tailored the criteria to children using terms appropriate to childhood functioning. We believe this approach provides a seamless set of severity criteria in the proposed listings from childhood into adulthood.<sup>23</sup>

We are not proposing to change the types of evidence we would consider when we rate the severity of a person’s limitations under the proposed paragraph B criteria. We know that most persons are not working when they apply for benefits; so, we must use information from their medical and other sources about how they function in their daily activities in order to draw conclusions about the functional limitations they would have in a work setting. This is essentially the same thing we do when we determine at step 2 of the sequential evaluation process that a person is limited in the ability to do basic work activities and when we assess residual functional capacity (RFC) for steps 4 and 5.

*Proposed 12.00C1—Understand, Remember, and Apply Information (Paragraph B1)*

In this section, we define the proposed paragraph B1 criterion and give examples of when a person uses this ability to perform work activities. We explain later in this preamble why we are proposing to remove the current paragraph B1 criterion, “activities of daily living.”

*Proposed 12.00C2—Interact With Others (Paragraph B2)*

In this section, we define the proposed paragraph B2 criterion and give examples of when a person uses this ability to relate to and work with supervisors, co-workers, and the public in a work setting. This criterion is related to, but would replace, the current paragraph B2 criterion, “social functioning.” We propose to remove some of the information in current 12.00C2 because it is not as useful in the context of the proposed B2 criterion as it is for the current criterion. For example, we propose to remove the current examples of limitation and strength in social functioning because we are proposing to focus on the mental abilities needed to work. In the proposed rule, we include examples of

<sup>20</sup> In explaining the change, we said:

We have always interpreted [the word “manifested”] to include the common clinical practice of inferring a diagnosis of mental retardation when the longitudinal history and evidence of current functioning demonstrate that the impairment existed before the end of the developmental period. Nevertheless, we also can see that the rule was ambiguous. Therefore, we expanded the phrase setting out the age limit to read: “i.e., the evidence demonstrates or supports onset of the impairment before age 22.”

65 FR at 50772, August 21, 2000.

<sup>21</sup> See, for example, the NRC report, pages 31 and 108.

<sup>22</sup> See especially Chapter 4 regarding the role of intelligence testing in diagnosing ID/MR.

<sup>23</sup> As we have already noted, and explain later in detail, we provide a somewhat different set of paragraph B criteria for children who have not attained age 3. However, those criteria are related to the proposed paragraph B criteria we would use for all other children and for adults.

what a person is expected to do when using the mental ability to interact with others in a work setting; for example, cooperating with co-workers or accepting criticism from a supervisor. An evaluation of the effects of a mental disorder on a person's mental ability to interact with others entails, among other things, a judgment of whether the person would be able to cooperate and accept criticism.

We would remove other information in current 12.00C2 about social functioning because we include it and give it more general application elsewhere in the proposed introductory text. For example, current 12.00C2 refers to social functioning as the "capacity to interact independently, appropriately, effectively, and on a sustained basis with other people," and explains that "[w]e do not define 'marked' by a specific number of different behaviors in which social functioning is impaired, but by the nature and overall degree of interference with function." These two general statements apply to the rating of impairment-related limitations for all the paragraph B criteria, not just social functioning. Therefore, in these proposed rules, we revise the statements slightly and include them in proposed 12.00D, where we define "marked" and "extreme" limitations for all four of the paragraph B mental abilities.

*Proposed 12.00C3—Concentrate, Persist, and Maintain Pace (Paragraph B3)*

The proposed paragraph B3 criterion is the same as the current paragraph B3 criterion, "maintaining concentration, persistence, or pace," except that we propose to change "or" to "and." This would not be a substantive change in the paragraph B3 criterion, but only a clarification of the overall requirement. In a work setting, just as a person is expected to understand, remember, and apply information, he or she is also expected to be able to concentrate, persist, and maintain pace.

We propose to move some of the information in current 12.00C3 to other sections of the proposed introductory text because the information includes useful guidance that applies to all of the proposed paragraph B criteria. For example, there is detailed information about clinical examinations, psychological testing, mental status examinations, and work evaluation, but we would consider these types of evidence when we assess limitations in the other paragraph B criteria too. For this reason, we propose to provide all the guidance about the medical and nonmedical evidence we may consider

under these listings in proposed 12.00G. What evidence do we need to evaluate your mental disorder?

We include information from the fifth paragraph of current 12.00C3 about "marked" limitation in proposed 12.00D1c. We also elaborate on what we mean by using a mental ability independently, appropriately, effectively, and on a sustained basis to function in a work setting.

*Proposed 12.00C4—Manage Oneself (Paragraph B4)*

The proposed paragraph B4 criterion would include aspects of functioning that we currently consider when we assess RFC, such as the ability to respond to demands and changes in the workplace. It reflects the critical role that self-management plays in being able to function independently, appropriately, effectively, and on a sustained basis in a work setting. It also includes the aspects of the current paragraph B1 criterion (activities of daily living) that deal with health and safety, as described in current 12.00C1.

**Proposal To Remove the Current Paragraphs B1 and B4 Criteria**

We propose to remove the current paragraph B1 criterion, activities of daily living (ADLs), because limitations in ADLs are the manifestation of limitations of any one, several, or sometimes all, of the four mental abilities in these proposed rules. For example, a person may have difficulty using public transportation or shopping (both of which are examples of ADLs in current 12.00C1) because of limitation of the ability to understand, remember, and apply information, the ability to interact with others, or both. These ADLs may also be limited by problems with the ability to concentrate or persist, or with the ability to manage oneself. Therefore, we do not believe that limitations in ADLs should be considered in a single separate area. Rather, we would use information about how the person functions in his or her ADLs, together with other information in the case record, to determine how the proposed four mental abilities are affected by the person's mental disorder. Since these abilities are necessary to function in a work setting, we would then be able to more realistically determine a person's capacity for work, even in situations in which he or she is not working or has never worked.

We describe the current paragraph B4 criterion—repeated episodes of decompensation, each of extended duration—in current 12.00C4 as "exacerbations or temporary increases in symptoms or signs accompanied by a

loss of adaptive functioning." We also explain that loss of adaptive functioning is manifested by difficulties in performing ADLs (current paragraph B1), maintaining social relationships (current paragraph B2), or maintaining concentration, persistence, or pace (current paragraph B3). Therefore, we seldom use the paragraph B4 criterion because we define it in terms of the first three current paragraph B criteria. This same redundancy would exist if we kept the paragraph B4 criterion with the proposed criteria.

We recognize that most mental disorders are subject to periods of exacerbation; therefore, in proposed 12.00G6, we continue to require adjudicators to consider temporary increases in symptoms and signs and their effect on a person's functioning over time when they rate limitations of the proposed paragraph B criteria. In the proposed paragraph C criteria, we would also continue to factor in a history of episodes of deterioration, as we explain below.

**Proposed 12.00D—How do we use the paragraph B mental abilities to evaluate your mental disorder?**

In this section, we propose to consolidate a provision that is in current 12.00A with guidance about rating impairment severity that appears in several different sections of current 12.00C. For example, in current 12.00C1, C2, and C3, we explain "We do not define 'marked' by a specific number of activities [or behaviors or tasks] in which functioning is impaired, but by the nature and overall degree of interference with function." Instead of stating it three times, we include this guidance in a single section, proposed 12.00D1c. We also propose to include guidance from our childhood disability rules that is applicable to evaluating mental disorders in adults and children.

*Proposed 12.00D1*

In this section, we provide general information about the paragraph B mental abilities. For example, we explain that:

- "Marked" or "extreme" limitation reflects the overall degree to which a mental disorder interferes with a person's use of an ability and does not necessarily reflect a specific type or number of activities that a person has difficulty doing.
- No single piece of information (including test scores) can establish whether a person has marked or extreme limitation.
- We consider the kind and extent of supports a person receives and the characteristics of any highly structured

setting in which the person spends time in order to function.

In proposed 12.00D1d, we state that the more extensive the supports or the more structure a person needs in order to function, the more limited we will find the person to be. This is a principle that we use in the childhood disability rules, and it is applicable to adults as well.<sup>24</sup>

*Proposed 12.00D2—What We Mean By “Marked” Limitation*

The proposed definition of “marked” limitation generally corresponds to the definitions in current 12.00C and 112.00C. We also incorporate provisions from § 416.926a, the regulation for functional equivalence for children, which provides a more detailed definition of the term than we do in the current mental disorders listings and which we propose to apply to adults.

One of the provisions from § 416.926a(e) that we are including in this definition explains that “marked” is the equivalent of functioning we would expect to find on standardized testing with scores that are at least two, but less than three, standard deviations below the mean. We added this provision to our functional equivalence rules in 2000<sup>25</sup> to codify guidance that we had given to our adjudicators during training.<sup>26</sup> We believe that this guidance is also useful for understanding the term as we apply it to adults and children under the mental disorders listings. A person whose functioning is two standard deviations below the mean is in approximately the second percentile of the population; that is, about 98 percent of the population functions at a higher level. It is also a meaningful concept to many mental health professionals.

We are not including in these proposed rules the description of “marked” as “more than moderate but less than extreme” from current 12.00C and 112.00C. Instead, we propose to use an explanation based on the language describing the rating scale for the Psychiatric Review Technique (PRT) in current §§ 404.1520a(c)(4) and

416.920a(c)(4) as a frame of reference to help define the terms “marked” and “extreme.” The rules for the PRT describe “marked” as the fourth point on a five-point rating scale—none, mild, moderate, marked, and extreme. In the proposed rules, we explain that we do not require our adjudicators to use such a scale, but that “marked” would be the fourth point on a scale of “no limitation, slight limitation, moderate limitation, marked limitation, and extreme limitation.” With this guideline, it is unnecessary to also state that “marked” falls between “moderate” and “extreme.” We use the word “slight” instead of “mild” to make clear that it is at a level consistent with an impairment that is not “severe,” as we explain the term in SSR 85–28,<sup>27</sup> and to preserve guidance that is consistent with the provision in current §§ 404.1520a(d)(1) and 416.920(a)(d)(1).

*Proposed 12.00D3—What We Mean By “Extreme” Limitation*

The proposed definition of “extreme” limitation is based on the definition in § 416.926a(e), and is in terms that are related to our definition of “marked.” For example, while “marked” limitation can generally be shown by a score on a standardized test that is at least two, but less than three, standard deviations below the mean, “extreme” limitation can generally be shown by a score that is at least three standard deviations below the mean. As we do in § 416.926a(e), we also explain that, while “extreme” is the rating we give to the worst limitations, it does not necessarily mean a total lack or loss of ability to function. Similarly to proposed 12.00D2, we also propose to provide a guideline based on §§ 404.1520a(c)(4) and 416.920a(c)(4) that describes “extreme” as the last point on a five-point rating scale.

*Proposed 12.00D4—How We Consider Your Test Results*

In this proposed section, we would clarify how we intend for our adjudicators to consider test scores under listing 12.05 or any other listing; that is, that the other objective medical evidence and the other evidence about the effects of a mental disorder on a person’s functioning must be consistent with the score. There continues to be confusion about the extent to which we rely on IQ scores in listing 12.05 or whenever we assess mental abilities or

functioning with IQ tests or other kinds of tests.

We based the language of the proposed rule on our policy for considering test results when we determine disability in children under SSI. Sections 416.924a(a)(1)(ii) and 416.926a(d)(4). This general policy is applicable to our evaluation of test results in claims of adults and children with mental disorders as well; so, we are proposing to incorporate it in the mental disorders listings. We include similar policy statements in our current mental disorders listings. In current 12.00D5c, we state, “In considering the validity of a test result, we should note and resolve any discrepancies between formal test results and the individual’s customary behavior and daily activities.” (Emphasis added.) In current 12.00D6a, we state, “[S]ince the results of intelligence tests are only part of the overall assessment, the narrative report that accompanies the test results should comment on whether the IQ scores are considered valid and consistent with the developmental history and the degree of functional limitation” (emphasis added).<sup>28</sup> We believe, however, that the language in the childhood regulations is clearer and more comprehensive.

**Proposed 12.00E—What are the paragraph C criteria, and how do we use them to evaluate your mental disorder?**

Both the current and proposed paragraph C criteria are alternative severity criteria for situations in which a person has achieved only marginal adjustment, and the symptoms and signs of his or her mental disorder are diminished because of psychosocial supports or treatment. The current paragraph C criteria for listings 12.02, 12.03, and 12.04 require a “Medically documented history of a [specified chronic mental disorder] of at least 2 years’ duration that has caused more than a minimal limitation of [the] ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support.” They also require one of three criteria described, in part, as:

<sup>28</sup> In current 12.00D5b, we also state that “a report of test results should include both the objective data and any clinical observations” that corroborate the data. This is another current rule that provides that we must consider whether the person’s functioning is consistent with the test score, although in this case it is in a clinical setting. Since we are proposing to remove the detailed guidance about testing that is in current 12.00D, we are proposing a new section 12.00B4d in the introductory text that will continue to address this issue for IQ testing in ID/MR.

<sup>24</sup> See, for example, §§ 416.924a(b)(5)(ii) and (b)(5)(iv); Social Security Ruling (SSR) 09–1p, “Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The ‘Whole Child’ Approach” (74 FR 7527 (2009)), available at: [http://www.socialsecurity.gov/OP\\_Home/rulings/ssi/02/SSR2009-01-ssi-02.html](http://www.socialsecurity.gov/OP_Home/rulings/ssi/02/SSR2009-01-ssi-02.html); and SSR 09–2p, “Title XVI: Determining Childhood Disability—Documenting a Child’s Impairment-Related Limitations” (74 FR 7625 (2009)), available at: [http://www.socialsecurity.gov/OP\\_Home/rulings/ssi/02/SSR2009-02-ssi-02.html](http://www.socialsecurity.gov/OP_Home/rulings/ssi/02/SSR2009-02-ssi-02.html).

<sup>25</sup> 65 FR 54747, 54757.

<sup>26</sup> Childhood Disability Training, SSA Office of Disability, Pub. No. 64–075, March 1997.

<sup>27</sup> SSR 85–28, “Titles II and XVI: Medical Impairments That Are Not Severe,” available at [http://www.socialsecurity.gov/OP\\_Home/rulings/di/01/SSR85-28-di-01.html](http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR85-28-di-01.html).



- Repeated episodes of decompensation, each of extended duration (C1);
- A residual disease process that has resulted in marginal adjustment (C2); or
- A current history of 1 or more years' inability to function outside a highly supportive living arrangement (C3).

We incorporate the same three criteria in the proposed rules, but we have simplified their content and application. For example, rather than counting the episodes of decompensation as required by current 12.00C4,<sup>29</sup> we simply require that the person have:

- A "serious and persistent" mental disorder with continuing treatment, psychosocial support, or a highly structured setting that diminishes the symptoms and signs of the disorder (proposed C1); and
- Marginal adjustment (proposed C2) as described in proposed 12.00E2c.

The description of marginal adjustment in proposed 12.00E2c includes essentially all of the current criteria, but is broader and, we believe, more accurate. We explain that marginal adjustment reflects a person's fragile existence in his or her environment, with minimal capacity to adapt to changes in the environment or demands that are not already part of his or her daily life. We believe that this approach more realistically reflects the nature of serious and persistent mental disorders.

The current paragraph C criterion for listing 12.06 "reflects the uniqueness of agoraphobia" (in current 12.00F) and requires the "complete inability to function independently outside the area of one's home." We continue to include this criterion under proposed listing 12.06C by providing in proposed 12.00E2c that "marginal adjustment" includes the inability to function "outside your home."

For accuracy and clarity, we propose to use the term "serious and persistent mental disorders" instead of "chronic mental impairments," as in current 12.00E. As used in the DSM-IV-TR, the word "chronic" is a "specifier" of certain mental disorders and provides information about the duration of certain diagnostic criteria. The duration varies by the disorder, and not all disorders have a "chronic" specifier. For example, the DSM-IV-TR uses "chronic" as a specifier for Posttraumatic Stress Disorder when symptoms last at least 3 months, but for a major depressive episode when the full criteria have been continuously met for 2 years. We are proposing to use a

<sup>29</sup> Three episodes within 1 year, or an average of once every 4 months, each lasting for at least 2 weeks.

completely separate term from the DSM-IV-TR so there is no confusion. We also believe that the proposed term is more descriptive of what we intend by the paragraph C criteria.

The term "serious and persistent mental disorders," is also similar to the terms "serious and persistent mental illness," (SPMI), "serious mental illness," and other descriptions used widely in Federal and State statutes and regulations, and in other areas related to mental health treatment and services. These terms generally refer to the same kinds of serious, chronic illnesses for which we intend the paragraph C criteria; for example, schizophrenia, bipolar disorder, major depressive disorder, agoraphobia, panic disorder, and posttraumatic stress disorder. We do not propose to adopt the exact term "SPMI" or any specific definition from other sources because there is no standard definition for the term, and some definitions would be narrower than we intend.<sup>30</sup>

In proposed 12.00E2a, we explain that a "serious and persistent mental disorder" is established by a medically documented history of the existence of the disorder over a period of at least 1 year. In order to satisfy the proposed paragraph C criteria, a person with a serious and persistent mental disorder must satisfy two additional criteria. He or she:

- Must be in continuing treatment, have psychosocial supports, or be in a highly structured setting (paragraph C1); and
- Must have achieved "only marginal adjustment" as defined in paragraph C2.

These two provisions describe a very serious impairment. Anyone who has a mental disorder that has persisted for at least 1 year and that satisfies the paragraph C1 and C2 criteria will by definition have a "serious and persistent mental disorder."

To ensure that we make allowances based on the paragraph C criteria as quickly as possible, we would also provide in proposed 12.00E1 that our adjudicators can apply the paragraph C criteria without first considering

<sup>30</sup> For example, in 2003, the President's New Freedom Commission on Mental Health defined "adults with a serious mental illness" as "persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R that has resulted in functional impairment which substantially interferes with, or limits one or more major life activities." (Citation in the References section of this preamble. Footnotes omitted.) For our disability determination purposes, the 12-month duration requirement in the Act applies instead of the various duration requirements in the DSM specific to different mental disorders.

whether the mental disorder satisfies the paragraph B criteria. Also, in proposed 12.00E2c, we use the word "deterioration" instead of "decompensation" in response to the public comments we have already described.

#### **Proposed 12.00F—How do we consider psychosocial supports, highly structured settings, and treatment when we evaluate your functioning?**

This section includes some of the information in the fourth paragraph of current 12.00C3 and current 12.00E, F, G, and H. We provide a greatly expanded list of examples of psychosocial supports and highly structured settings in proposed 12.00F2 and guidance about the effects of treatment in proposed 12.00F3. These changes respond to comments from several sources who recommended that the proposed rules should reflect the fact that controlling a person's symptoms with medications and community supports does not eliminate the underlying mental disorder and that we should not interpret evidence of a person's active involvement in a supported work setting by itself to mean that the person is not disabled.

#### **Proposed 12.00G—What evidence do we need to evaluate your mental disorder?**

Proposed 12.00G corresponds to the information in current 12.00D1 through D3; however, we have expanded the information from the current rules and reorganized it in what we believe is a more user-friendly format.

We have not included text corresponding to current 12.00B, Need for medical evidence, because the information in that section is unnecessary, appears in other regulations, or appears in other provisions of these proposed rules.<sup>31</sup> Also, the last two sentences of current 12.00B explain that symptoms and signs cluster together to constitute recognizable mental disorders described in the listings, and that the symptoms and signs may be intermittent or continuous. We believe this information is too general to be helpful and would be unnecessary in these proposed rules given the information we provide in proposed 12.00B. We also provide guidance about mental disorders that are subject to exacerbations and

<sup>31</sup> For example, the rule in current 12.00B that we must establish the existence of a medically determinable impairment that meets the duration requirement also appears in §§ 404.1508, 404.1509, 404.1520, 416.908, 416.909, and 416.920 of our regulations.

remissions—that is, that can be intermittent—in proposed 12.00G6.

Likewise, we do not include the rule in the first paragraph of current 12.00D that the medical evidence must be sufficiently complete and detailed as to symptoms, signs, and laboratory findings to permit an independent determination. We already have a provision that says essentially the same thing. Sections 404.1513(e) and 416.913(e).

#### *Proposed 12.00G1—General*

Proposed 12.00G1 explains that we need evidence to assess the existence and severity of a person's mental disorder and its effects on the person's ability to function in a work setting. We also include guidance about the evidence we need from acceptable medical sources<sup>32</sup> and other sources and include references to our basic rules on evidence and symptoms.

As we note below, we are proposing to remove current 12.00D4, which describes mental status examinations. However, we have included a sentence in proposed 12.00G1 that is based on the last sentence of current 12.00D4. The current sentence provides that the individual facts of a case determine the specific areas of mental status that must be emphasized during a mental status examination. We propose to revise that statement so that it applies to all evidence, not just mental status examinations; that is, to provide that individual case facts determine the type and extent of evidence we need to make our determination or decision. This will help to clarify that we do not need, and will not ask for, evidence from all of the sources we describe in 12.00G in every case.

#### *Proposed 12.00G2—Evidence From Medical Sources*

In proposed 12.00G2, we reorganize and expand the information in current 12.00D1a and incorporate information from current 12.00D1c to explain that we will consider all relevant evidence from the person's physician or psychologist and from other medical sources who are not "acceptable medical sources," such as therapists and licensed clinical social workers. We include information about other medical sources under the heading, "Evidence from medical sources," rather than "Other information," as in current 12.00D1c, because we consider these sources to be

<sup>32</sup> "Acceptable medical sources" are physicians, licensed or certified psychologists, and certain other types of medical sources who can provide evidence to establish the existence of a medically determinable impairment. Sections 404.1513(a) and 416.913(a).

kinds of "medical sources" under §§ 404.1513(d)(1) and 416.913(d)(1) of our regulations. While only certain persons, such as physicians and licensed or certified psychologists, are "acceptable medical sources," we agreed with commenters who said that we should emphasize the role that other medical sources can play in our disability evaluations. For this reason, we also provide that evidence from other medical sources can be "especially helpful" to our assessment of the severity of mental disorders and their effects on functioning. This provision is consistent with guidance we provide in SSR 06–3p.<sup>33</sup>

We also provide an expanded list of the types of evidence that may be available from medical sources. The list includes the information in current 12.00D1a regarding cultural background and sensory, motor, and speaking abnormalities that may affect our evaluation of a person's mental disorder. Finally, we do not include information from current 12.00D1a that only repeats provisions of our other regulations.

We propose to remove current 12.00D4, which discusses the mental status examination in detail. Current 12.00D4 does not provide any rules for our adjudicators to apply, and the elements of the mental status examination are more thoroughly and effectively described in standard psychiatric and psychological textbooks. We also provide guidance about the elements of mental status examinations in the booklet, *Consultative Examinations: A Guide for Health Professionals*.<sup>34</sup> In the proposed rules, we list the mental status examination as one aspect of the evidence we typically expect from medical sources.

We also propose to remove current 12.00D11, which describes the documentation needed for specific anxiety disorders. Although the paragraph uses words that are specific to anxiety disorders, it does not require anything that we would not ordinarily require to evaluate other mental disorders. For example, it requires information about a typical reaction, and if there are panic attacks, a description of the nature, frequency, and duration of the attacks, the

<sup>33</sup> SSR 06–3p, "Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not 'Acceptable Medical Sources' in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies," 71 FR 45593 (2006). Also available at: [http://www.socialsecurity.gov/OP\\_Home/rulings/di/01/SSR2006-03-di-01.html](http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR2006-03-di-01.html).

<sup>34</sup> SSA Pub. No. 64–025, November 1999. Available at: <http://www.socialsecurity.gov/disability/professionals/greenbook/index.htm>.

precipitating and aggravating factors, and the functional limitations that result. This is a description of how we evaluate any impairment that is subject to exacerbations, and we would consider the same kinds of information in evaluating any such mental disorder. It is also similar to our rules for evaluating symptoms in §§ 404.1529 and 416.929. Likewise, the information in the paragraph about descriptions of a person's anxiety reaction from medical and other sources is already covered by other rules, including proposed 12.00G, in which we would provide extensive information about the kinds of evidence we may obtain from medical and other sources.

#### *Proposed 12.00G3—Evidence From You and Persons Who Know You*

Proposed 12.00G3 corresponds to current 12.00D1b and the second sentence of current 12.00D1c. In the proposed rule, we have simplified the language and removed unnecessary statements.

#### *Proposed 12.00G4—Evidence From School, Vocational Training, Work, and Work-Related Programs*

Proposed 12.00G4 generally corresponds to the last sentences of current 12.00D1c and 12.00D3, but we propose to add information about school evidence and to expand the information about vocational training and work-related programs. We also explain that we will consider information from work attempts or current work activity when we need it to show the severity of a person's mental disorder and how it affects his or her ability to function.

#### *Proposed 12.00G5—Evidence From Psychological and Psychiatric Measures*

We propose to remove the detailed information on psychological testing in current 12.00D5 through D9 because most of this information is educational and procedural, and tests are constantly being revised and updated. Instead, we would provide general and policy-related test information in an SSR.<sup>35</sup> Therefore, in this section we would explain only in general terms how we consider the results of psychological and psychiatric measures.

#### *Proposed 12.00G6—Need for Longitudinal Evidence*

Proposed 12.00G6 generally corresponds to current 12.00D2, although we have slightly expanded the

<sup>35</sup> However, we are proposing to include a provision that explains how we decide whether an IQ test score is "valid" in proposed 12.00B4d and general guidance for considering test results in proposed 12.00D4.

provisions and changed some of the terms we use. In 12.00G6a, we explain that we will consider how a person functions longitudinally, taking into consideration any periods of exacerbation or remission. We explain that we will not make a determination based solely on periods of exacerbation or remission, but will consider all factors related to these occurrences and any other relevant evidence so that we understand how a person functions over time.

Proposed 12.00G6b is new. It explains that, if a person has a serious mental disorder, we would expect there to be evidence of its effects on his or her functioning over time, even if the person does not have an ongoing relationship with the medical community. Such evidence could come, for example, from family members, neighbors, or former employers.

Proposed 12.00G6c generally corresponds to the fourth paragraph of current 12.00C3. It explains that a person's ability to function in an unfamiliar or one-time situation, such as a consultative examination, does not necessarily show how he or she will be able to function in a work setting under the stresses of a normal workday and workweek on a sustained basis.

Proposed 12.00G6d is new. It explains how we consider the effects of stress. We based the proposed provisions on guidance in SSR 85–15.<sup>36</sup> Although this SSR is specifically about evaluating disability at step 5 of the sequential evaluation process, its guidance about stress is also relevant to other steps of the process.

#### **Proposed 12.00H—How do we evaluate substance use disorders?**

We propose to add this section because we are also proposing to remove listing 12.09, Substance addiction disorders, for reasons we explain later in this preamble. We explain the requirement in the Act and our regulations<sup>37</sup> that, if we find a person disabled and there is medical evidence establishing a substance use disorder, we must determine whether the disorder is a contributing factor material to the determination of disability. We also include a reference

<sup>36</sup> SSR 85–15, “Titles II and XVI: Capability To Do Other Work—The Medical-Vocational Rules As a Framework for Evaluating Solely Nonexertional Impairments,” available at: [http://www.socialsecurity.gov/OP\\_Home/rulings/di/02/SSR85-15-di-02.html](http://www.socialsecurity.gov/OP_Home/rulings/di/02/SSR85-15-di-02.html).

<sup>37</sup> Sections 223(d)(2)(C) and 1614a(3)(J) of the Act; §§ 404.1535 and 416.935 of the regulations. In drafting this rule, we also considered whether to propose revisions and updates to §§ 404.1535 and 416.935. We decided that, if we propose revisions to those rules, we should do so in a separate NPRM.

to our rules for this policy. Sections 404.1535 and 416.935.

#### *12.00I—How do we evaluate mental disorders that do not meet one of the mental disorders listings?*

Although this proposed section would be new to the mental disorders listings, it is in large part similar to guidance we provide in other body systems; for example, 4.00I3 (Cardiovascular System), 8.00H (Skin Disorders), and 13.00F (Malignant Neoplastic Diseases). We also explain that a mental disorder may cause a physical impairment(s) and how we would evaluate such an impairment(s). We include an example of a cardiovascular impairment that results from an eating disorder to clarify the guidance in current 12.00D12 (Eating Disorders), which reminds adjudicators to consider the physical consequences of eating disorders.

#### *12.01 Category of Impairment, Mental Disorders*

#### **Proposal To Remove the Introductory Paragraphs and Paragraph A Criteria**

We believe that the current paragraph A criteria in each listing (except for current listing 12.05) are too prescriptive; they omit from the listings mental disorders that we often see in disability claims. The proposal to remove the paragraph A criteria would make the listings more comprehensive by including any and all mental disorders that can be identified within a listing category. By including such disorders, we would address questions from our adjudicators about which listings to use to evaluate some mental disorders not described by the current paragraph A criteria. The proposed change would also make the mental disorders listings consistent with many of our other listings. For example, we have a number of musculoskeletal and neurological listings that describe categories of impairments rather than specific diagnoses. As in the proposed mental disorders listings, listing-level severity in these listings is shown by limitations of functioning.

The proposed changes would also respond in part to the many commenters on the ANPRM who suggested specific mental disorders that we should add to the current listings. While adding names of specific mental disorders to the listings would broaden their scope somewhat, it could still omit some mental disorders within each listing category. The proposed rules allow us to include the disorders the commenters asked us to add and more.

The proposed change would also simplify our adjudication of some

allowances by reducing the number of cases in which we must make more labor-intensive determinations of medical equivalence. For example, because of the paragraph A criteria, we do not list dysthymic disorder and cyclothymic disorder in current listing 12.04; when these relatively common mental disorders are of listing-level severity, we must make a finding of medical equivalence to listing 12.04 and explain why they medically equal the listing. Under the proposed rules, if a person with one of these disorders has limitations in functioning that satisfy the paragraph B or paragraph C criteria, the disorder would meet listing 12.04.

In drafting these proposed rules, we were mindful of possible concerns that the listings would no longer provide specific criteria that adjudicators could identify in order to establish the existence of a specific mental disorder under a listing. For example, we considered whether our adjudicators might need to refer to the DSM more often and whether administrative law judges (ALJs) might have to use more medical experts at hearings. We do not believe that the proposed rules should be a cause for these kinds of concerns because our adjudicators already make determinations about the nature of mental disorders apart from the issue of “meeting” listings, and the proposed listings put less emphasis on the need to establish a specific diagnosis than the current rules do. In this regard, adjudicators would only continue to do what they do now: we do not believe that they will need to consult the DSM or that ALJs will need medical expert testimony with greater frequency.<sup>38</sup> The major difference will be that, after determining the existence and nature of the mental disorder, our adjudicators will not then have to make findings about whether there is evidence demonstrating specific paragraph A criteria prescribed in each of the current listing categories. This change will simplify our current rules.

#### **Proposed Changes to Specific Listings in This Body System**

##### **Proposed Listing 12.05**

We propose to make minor editorial revisions in current listing 12.05. As we show in the chart below, current listing 12.05 starts with an introductory paragraph that provides our diagnostic description of mental retardation. The

<sup>38</sup> The DSM also includes many diagnoses that are characterized as “NOS”: Not Otherwise Specified. Partly because of these diagnoses, we expect that there will be fewer issues about whether a person has a particular kind of mental disorder that requires additional development or rationale to explain the finding about the nature of the disorder.

current listing also includes four sets of severity criteria (paragraphs A through D). If a person’s mental disorder satisfies the diagnostic description in the introductory paragraph and any one of the four sets of criteria, we find that it meets the listing. As with all of the other mental disorders listings, we propose to remove the introductory paragraph of listing 12.05. Unlike in the other listings, however, we would

incorporate by reference two of the elements of the diagnostic description (“significantly subaverage general intellectual functioning” and “significant deficits of adaptive functioning”) into each of the proposed listings by requiring that a person demonstrate ID/MR “as defined in 12.00B4.” Although we have clarified the current listing on several occasions—both in the listing itself and

in other instructions—there continues to be some confusion about whether a person’s impairment must satisfy the definition of “mental retardation” in the introductory paragraph of listing 12.05 and what that definition means. We hope to lessen that confusion by including a reference to the definition within each section of listing 12.05.

Below is a chart comparing current listing 12.05 with our proposed changes:

Current listing 12.05	Proposed listing 12.05
<p>12.05 Mental retardation: Mental retardation refers to significantly subaverage general intellectual functioning with deficits in adaptive functioning initially manifested during the developmental period; <i>i.e.</i>, the evidence demonstrates or supports onset of the impairment before age 22.</p> <p>The required level of severity for this disorder is met when the requirements in A, B, C, or D are satisfied.</p> <p>A. Mental incapacity evidenced by dependence upon others for personal needs (<i>e.g.</i>, toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded;</p> <p>OR</p> <p>B. A valid verbal, performance, or full scale IQ of 59 or less;</p> <p>OR</p> <p>C. A valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing an additional and significant work-related limitation of function;</p> <p>OR</p> <p>D. A valid verbal, performance, or full scale IQ of 60 through 70, resulting in at least two of the following:</p> <ol style="list-style-type: none"> <li>1. Marked restriction of activities of daily living; or</li> <li>2. Marked difficulties in maintaining social functioning; or</li> <li>3. Marked difficulties in maintaining concentration, persistence, or pace; or</li> <li>4. Repeated episodes of decompensation, each of extended duration.</li> </ol>	<p>12.05 Intellectual Disability/Mental Retardation (ID/MR) satisfying A, B, C, or D.</p> <p>A. ID/MR as defined in 12.00B4, with mental incapacity evidenced by dependence upon others for personal needs (for example, toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded.</p> <p>OR</p> <p>B. ID/MR as defined in 12.00B4, with a valid IQ score of 59 or less (as defined in 12.00B4d) on an individually administered standardized test of general intelligence having a mean of 100 and a standard deviation of 15 (<i>see</i> 12.00D4).</p> <p>OR</p> <p>C. ID/MR as defined in 12.00B4, with a valid IQ score of 60 through 70 (as defined in 12.00B4d) on an individually administered standardized test of general intelligence having a mean of 100 and a standard deviation of 15 (<i>see</i> 12.00D4) and with another “severe” physical or mental impairment (<i>see</i> 12.00B4e).</p> <p>OR</p> <p>D. ID/MR as defined in 12.00B4, with a valid IQ score of 60 through 70 (as defined in 12.00B4d) on an individually administered standardized test of general intelligence having a mean of 100 and a standard deviation of 15 (<i>see</i> 12.00D4), resulting in <i>marked</i> limitation of at least two of the following mental abilities:</p> <ol style="list-style-type: none"> <li>1. Ability to understand, remember, and apply information (<i>see</i> 12.00C1).</li> <li>2. Ability to interact with others (<i>see</i> 12.00C2).</li> <li>3. Ability to concentrate, persist, and maintain pace (<i>see</i> 12.00C3).</li> <li>4. Ability to manage oneself (<i>see</i> 12.00C4).</li> </ol>

Proposed listing 12.05D corresponds to current listing 12.05D, but refers to the proposed paragraph B criteria instead of the current paragraph B criteria. Otherwise, it is the same as the current listing.

**Proposal To Remove Current Listing 12.09**

We propose to remove current listing 12.09, Substance Addiction Disorders, because it is a reference listing. Reference listings refer to criteria in other listings and are redundant because we use the other listings to evaluate disability. For example:

- An impairment meets current listing 12.09A by meeting the criteria for any listing under 12.02 for organic mental disorders.

- An impairment meets current listing 12.09F by meeting the criteria in listing 5.05 for chronic liver disease.

In both cases, claimants who qualify under these listings would still qualify under the listings to which they cross-refer, provided that their substance use disorders are not material to our determination of disability. We have been removing reference listings from all of the body systems as we revise them, and the changes we are proposing in this NPRM would be consistent with that approach.<sup>39</sup>

If we remove listing 12.09, we would also remove the fifth paragraph of

<sup>39</sup>Examples of relatively recent such changes include the “Revised Medical Criteria for Evaluating Digestive Disorders,” 72 FR 59398 (October 19, 2007), and the “Revised Medical Criteria for Evaluating Immune System Disorders,” 73 FR 14570 (March 18, 2008).

current 12.00A, because it explains how listing 12.09 is structured. As we have already noted, however, we are proposing a new section 12.00H that would briefly state our policy on how, in our disability determinations, we consider the effects of substance use disorders. The proposed section would also provide a cross-reference to our rules for determining whether a substance use disorder is a contributing factor material to disability. Sections 404.1535 and 416.935.

**Proposed Listings 12.11 and 12.13**

Proposed listing 12.11, Other Disorders Usually First Diagnosed in Childhood or Adolescence, is based on the first diagnostic category in the DSM–IV–TR and would correct some omissions in our current listings.

Proposed listing 12.13, Eating Disorders, would provide a listing for adults that corresponds to a childhood listing we have had since 1990. We agreed with several commenters on the ANPRM who asked us to add a listing for eating disorders in adults since we use childhood listings only for persons who are under age 18 (including persons who are nearly age 18), but persons age 18 and older also have these disorders. As a consequence of this proposed change, we would also remove most of the guidance we now provide in 12.00D12 because we would no longer need it.

Under our current listings, adjudicators can find that the disorders we would cover under proposed listings 12.11 and 12.13 medically equal a listing. Thus, the principal effect of adding these listings would be to streamline our processing of cases that involve these impairments.

#### **Proposed 112.00—Introductory Text to the Childhood Mental Disorders Listings**

We repeat much of the introductory text of proposed 12.00 in the introductory text of proposed 112.00. This is because the same basic rules for evaluating mental disorders in adults also apply to mental disorders in children from birth to the attainment of age 18. Because we have already described these provisions above, the following discussions describe only those provisions that are unique to the childhood rules or that require further explanation. We describe only the major provisions pertinent to 112.00. For example, we do not explain:

- References to “children” instead of adults;
- References to a child’s ability to do age-appropriate activities, as opposed to an adult’s ability to function in a work setting;
- References to the functional equivalence provision at step 3 of the sequential evaluation process for children instead of steps 4 and 5 of the process for adults; and
- Examples for children that are different from the examples we provide for adults, such as the information about the listing categories in 12.00B and 112.00B.

As a result of replacing all of current 112.00A with text that is the same as, or similar to, proposed 12.00A and B, we would remove the following provisions, among others:

- The second paragraph of current 112.00A, which explains that there are certain diagnostic categories applicable only to children and that the presentation of mental disorders in

children differs significantly from the signs and symptoms of the same disorders in adults. These explanations in the current rules ensure that adjudicators appropriately evaluate medically determinable mental disorders in children. In the proposed rules, we describe such differences more specifically in proposed 112.00B; for example, we include examples of early childhood eating disorders (proposed listing 112.13) that are not appropriate for the adult listing. We also provide age-appropriate paragraph B criteria for infants and toddlers in proposed 112.00I.

- The seventh paragraph of current 112.00A, which explains why we do not include separate paragraph C criteria in current listings 112.02, 112.03, 112.04, and 112.06. We would not need this paragraph because we are now proposing to include the same paragraph C criteria in the childhood listings that we propose for the adult rules.

#### **Proposed 112.00I**

In proposed 112.00I of the introductory text—How do we use 112.14 to evaluate developmental disorders of infants and toddlers from birth to attainment of age 3?—we include the same kinds of information for infants and toddlers as we do for older children in the other sections of the introductory text. For example, we describe “developmental disorders” and define the four proposed paragraph B criteria for infants and toddlers and the terms “marked” and “extreme” for this age group.<sup>40</sup> We also include information about how we consider supports an infant or toddler receives.<sup>41</sup>

In proposed 112.00I2, we describe only the broad characteristics of developmental disorders rather than specific characteristics of any particular medically determinable impairment that would be identified as a developmental disorder. Unlike the proposed adult listing categories and the other proposed child listing categories—which include related kinds of mental disorders under each listing category—proposed listing 112.14 would include several kinds of unrelated disorders; for example, pervasive developmental disorders, developmental coordination disorder, and “developmental delay.” We believe that any summary of the symptoms and

signs associated with the various disorders we would evaluate under proposed listing 112.14, however brief, would be too lengthy.

In proposed 112.00I6, we would expand our rules for deferring a determination for infants, now in current 112.00D2. The provisions recognize that young infants typically experience some irregularities in observable behaviors (such as sleep cycles, attending to faces, and self-calming), which can make it difficult to document the presence, severity, or duration of a developmental disorder(s). In some cases, deferring our determination allows us to obtain a longitudinal medical history and, if necessary, standardized developmental testing. The rule in proposed 112.00I6a addresses full-term infants who have not attained age 6 months, while proposed 112.00I6b addresses infants who were born prematurely. We also propose to update the rule for premature infants to reflect our rules in § 416.924b(b) for adjusting age for prematurity.

Current 112.00D2 provides that we may defer adjudication for full-term infants until they are 3 months old and to an unspecified older age for premature infants. We propose to change this rule to say that, when we must defer adjudication in these claims, we will wait until the child is at least 6 months old regardless of whether he or she was born full term or prematurely. We would use chronological age for full-term infants and corrected chronological age for premature infants. Based on our adjudicative experience and the information we obtained when we developed these proposed rules, we believe that 3 months is inadequate to establish whether some infants have listing-level developmental disorders. However, we also explain in proposed 112.00I6c that we will not always defer adjudication. There will be many cases in which we can determine that an infant younger than age 6 months has a developmental disorder that meets or medically equals proposed listing 112.14 or a listing in another body system or a combination of impairments that functionally equals the listings. There will also be cases in which we can determine that a child is not disabled before age 6 months. We would defer adjudication only when it appears that an infant has a significant developmental delay but we need to wait so that we can get adequate evidence to be sure of our determination.

<sup>40</sup> We define the terms “marked” and “extreme” as they apply to infants and toddlers in proposed 112.00I4c, d, e, and f. The definitions generally reflect those in the functional equivalence regulation.

<sup>41</sup> We also address issues related to developmental disorders in proposed 112.00G, the section on evidence.

### 112.01 Category of Impairment, Mental Disorders

The proposed childhood listing categories are the same as the adult categories, except that we are also proposing new listing 112.14 for children from birth to the attainment of age 3. As a consequence of this new listing, we would also remove listing 112.12, which is for children from birth to the attainment of age 1. As we noted earlier, we describe only those provisions that are unique to the childhood rules.

#### Proposed Listing 112.05

Proposed listing 112.05 is the same as proposed listing 12.05. As in all the other proposed listings, we are making changes to remove references to children under age 3 because of our new proposed listing 112.14, which is for all children from birth to the attainment of age 3.

Current listing 112.05 has six paragraphs, designated A through F. We propose to remove listings 112.05A and F so that listings 112.05 and 12.05 are the same. Current listings 112.05B, C, D, and E correspond to current adult listings 12.05A, B, C, and D. As we have already explained, we are proposing to keep current listings 12.05A, B, C, and D with minor changes we have already described, and we would do the same for children, redesignating the listings so they have the same letters; for example, current listing 112.05B would become listing 112.05A and current listing 112.05E would become listing 112.05D. There are also minor differences between the proposed child and adult rules because we need to use language specific to children.

We would remove current listing 112.05A and F because we do not believe we need them. Current listing 112.05A would be redundant of other proposed listings. A child age 3 or older with ID/MR has a mental disorder that meets this listing with “marked” limitations in at least two of the current paragraph B functional criteria for children. Under proposed 112.05B, a child with ID/MR with a valid IQ of 59 or less would have an impairment that meets the listing without reference to the paragraph B functional criteria.<sup>42</sup> Under proposed 112.05D, a child with ID/MR with an IQ of 60 to 70 and “marked” limitations in two of the proposed paragraph B criteria would have an impairment that meets that listing.<sup>43</sup> Thus, proposed listings

112.05B and D would cover any child with ID/MR who could qualify under current listing 112.05A.

Current listing 112.05F is a variation on current listing 112.05D, the listing for children who have ID/MR with an IQ of 60–70 and another “severe” physical or mental impairment. Instead of requiring an IQ of 60–70, current listing 112.05F requires that the child have a “marked” limitation of the first paragraph B criterion, “cognitive/communicative function.” In our adjudicative experience, we do not see cases of children whose impairments meet this listing. In the unlikely event that we receive a claim in which a child appears to have ID/MR but has not had IQ testing, we will purchase IQ testing to determine whether the impairment meets proposed listing 112.05C unless we can find that the child is disabled on some other basis, such as under our rules for functional equivalence in § 416.926a.

#### Proposal To Remove Listing 112.09

Current listing 112.09, Psychoactive Substance Dependence Disorders, is different from current listing 12.09 in that it is not a reference listing; rather, it consists of an introductory paragraph and paragraph A and B criteria. We are proposing to remove it because children with substance use disorders must satisfy the same requirement that applies to substance use disorders in adults; that is, if we find that a child is disabled, we must also determine whether the child’s substance use disorder is a contributing factor material to our determination of disability. Section 416.935. When we find that a child is disabled because of a substance use disorder that meets listing 112.09, the substance use disorder is always material to the determination of disability, and a child cannot qualify for benefits based on a mental disorder that meets listing 112.09.

#### Proposed Listing 112.14— Developmental Disorders of Infants and Toddlers

We propose to replace current listing 112.12, Developmental and Emotional Disorders of Newborn and Younger Infants (Birth to attainment of age 1), with a new listing 112.14, Developmental Disorders of Infants and Toddlers, that we will use to evaluate these disorders in children from birth to

<sup>42</sup> 112.05E requires a “valid” IQ of 60–70, which means that the child must have a “marked” limitation in the first paragraph B criterion for children, “cognitive/communicative function.” The rest of current listing 112.05E requires a “marked” limitation in one of the three remaining paragraph B criteria.

the attainment of age 3. We would no longer have separate criteria for children from age 1 to the attainment of age 3 in the other mental disorders listings because we would evaluate all mental disorders for children in that age group under proposed listing 112.14.

#### How We Evaluate Children From Birth to Age 3 Under the Current Listings

Current listing 112.12 includes four areas for rating severity in children from birth to age 1: Cognitive/communicative functioning; motor development; apathy, over-excitability, or fearfulness; and social interaction. We evaluate the mental disorders of children age 1 to the attainment of age 3 under the same listings as for older children; that is, current listings 112.02 through 112.11. However, we provide separate severity criteria for this age group and only three paragraph B criteria: Motor development, cognitive/communicative function, and social function.

Children in both groups (birth to the attainment of age 1 and age 1 to the attainment of age 3), can qualify under the current listing by showing extreme limitation of one paragraph B criterion or marked limitations of two. For both age groups, we define the severity ratings in terms of the attainment of developmental milestones: for extreme limitation, the attainment of development or functioning at a level generally acquired by children no more than one-half the child’s chronological age, and for marked limitation, the attainment of development or functioning at a level generally acquired by children no more than two-thirds the child’s chronological age.

#### Proposed Listing 112.14

Proposed listing 112.14 is similar in structure to the other proposed listings for children and adults. It would require a child to have a developmental disorder that results in extreme limitation in using one, or marked limitations in using two, developmental abilities to acquire and maintain the skills a child needs to function age-appropriately. The four proposed paragraph B criteria for this age group are:

- The ability to plan and control motor movement (paragraph B1),
- The ability to learn and remember (paragraph B2),
- The ability to interact with others (paragraph B3), and
- The ability to regulate physiological functions, attention, emotion, and behavior (paragraph B4).

These criteria are similar to the current severity criteria for both age groups and describe the developmental

<sup>42</sup> This redundancy occurs in the current listing too.

<sup>43</sup> Although the rule is less clear, this redundancy also occurs in the current listing. Current listing

abilities typically assessed in children from birth to age 3.

- The proposed paragraph B1 criterion would serve the same function as the “motor” criteria for children from birth to age 1 in current listing 112.12B and age 1–3 in current listing 112.02B1a.

- The proposed paragraph B2 criterion would address abilities covered in “cognitive/communicative functioning” in current listings 112.12A and 112.02B1b.<sup>44</sup>

- The proposed paragraph B3 criterion would address the ability covered in “social function” in current listings 112.12D and 112.02B1c.

- The proposed paragraph B4 criterion would address the problems with self-regulation in current listing 112.12C, “Apathy, over-excitability, or fearfulness, demonstrated by an absent or grossly excessive response to visual, auditory, or tactile stimulation.”

The fourth proposed paragraph B criterion would also allow us to consider more developmental issues than we now do under listing 112.12C. It reflects recent literature regarding early child development.<sup>45</sup>

We are proposing to evaluate infants and toddlers in a single age grouping for several reasons. We believe that, from the perspective of medical evaluation and diagnosis, the developmental period of birth to the attainment of age 3 is better viewed as a continuum rather than two distinct age groups. We also believe that it is more appropriate to consider children age 1–3 in terms of their development and “developmental disabilities” or “developmental disorders,” not of the mental disorder categories that we propose to use for older children and adults. Medical and health care professionals in the field of infant and early childhood mental health have not reached consensus on appropriate mental disorder diagnoses for this age group. Except in cases involving the most profound and obvious impairments, many pediatricians and developmental specialists prefer to wait until a child is age 3 or older before making a definitive diagnosis; in cases of children who are under age 3, we often see a diagnosis of “developmental delay.”

We propose to use the term “developmental disorders” instead of

<sup>44</sup> In those two listings, for children from birth to age 3 for whom standardized intelligence testing may not be appropriate because of the child’s young age or condition, we can use evidence about the child’s communication as an alternative to, or proxy for, evidence about the child’s cognitive functioning, which is the focus of the area of “cognitive/communicative functioning.”

<sup>45</sup> See the References section of this preamble.

the term in current listing 112.12, “emotional and developmental disorders,” because we believe it is sufficiently broad to encompass all aspects of a young child’s development, including emotional disorders.

The proposed paragraph B developmental abilities for children from birth to age 3 are also related to the proposed paragraph B mental abilities for children ages 3–18:

- The ability to learn and remember corresponds to the paragraph B1 criterion for children age 3–18, the ability to understand, remember, and apply information.

- The ability to interact with others is the same as the paragraph B2 criterion for children age 3–18.

- The ability to regulate physiological functions, attention, emotion, and behavior corresponds to the proposed paragraphs B3 and B4 criteria for children age 3–18. We would combine these abilities under one criterion to reflect clinical practice and the fact that the abilities are differentiated less well in children from birth to age 3. When a child attains age 3, we would assess his or her ability to regulate attention under the proposed B3 criterion for children age 3 and older (the ability to concentrate, persist, and maintain pace) and the child’s ability to regulate physiological functions, emotion, and behavior under the proposed B4 criterion for such children (the ability to manage oneself).

#### **Why are we proposing to remove §§ 404.1520a and 416.920a, Evaluation of Mental Impairments?**

In the 1985 rules, we introduced the PRT as an adjudicative tool for evaluating disability in adults due to mental disorders.<sup>46</sup> Sections 404.1520a and 416.920a. The purpose of the technique was to help our adjudicators organize and evaluate all the findings in the case to ensure fair and equitable disability evaluations. There was concern at the time that the new listings were novel and complex, so in conjunction with the publication of the new adult mental disorder listings in 1985, we also mandated in the regulations the use of a “standard document,” called the Psychiatric Review Technique Form or “PRTF” (SSA–2506–BK), to ensure that adjudicators at all levels of administrative review would properly apply the new listings.

We are now proposing to remove these sections because we believe that we will no longer need the PRT if we

<sup>46</sup> We never extended the use of the PRT to children.

publish the proposed listings. Although not exclusively for applying the listings, the PRT is mostly related to the use of the listings, and the changes we are proposing would make the PRT less useful in this regard. For example, most pages of the PRTF restate the paragraph A diagnostic criteria from the current listings, and we do not have such criteria in the proposed listings.<sup>47</sup> Our adjudicators can record the other findings associated with the PRT and the PRTF (for example, how they rate the paragraph B criteria and whether an RFC assessment is needed) on other documents. In fact, in 2000 we removed the requirement for ALJs and the Appeals Council to complete the PRTF because they already explain in their decisions how they apply the PRT rules.<sup>48</sup> We also plan to provide standard electronic decision templates at all levels of review, and these templates will document the findings in mental disorder determinations and decisions at each of the relevant steps of our process for determining disability. We already use such templates in decisions at the hearing level of our administrative review process.<sup>49</sup>

There are provisions of §§ 404.1520a and 416.920a that we are proposing to keep in the same or similar form in other sections of these proposed rules, as follows:

1. In current §§ 404.1520a(e)(1) and 416.920a(e)(1), we provide that State agency medical and psychological consultants have the overall responsibility for assessing the medical severity of mental impairments. We also provide that a State agency disability examiner may assist in preparing the PRTF; however, the medical or psychological consultant with overall responsibility for assessing the mental impairment must review and sign the document to attest that it is complete and that he or she is responsible for its content. We also provide rules requiring disability hearing officers, ALJs, and the Appeals Council (when the Appeals Council makes a decision), to document how they applied the PRT in their determinations and decisions.

We believe that, with appropriate changes to reflect the removal of the

<sup>47</sup> It would also not be useful to have a form that repeats the examples and summary guidance in proposed 12.00B since the examples and summaries are primarily informational. As we explained earlier in this preamble, proposed 12.00B generally provides only examples to illustrate the kinds of mental disorders that are included in the listing categories.

<sup>48</sup> 65 FR at 50757–58.

<sup>49</sup> The system of templates used at the hearing level is called “Findings Integrated Templates,” or FIT. You can read about FIT at: <http://www.socialsecurity.gov/appeals/fit/>.

PRT and PRTF, the provisions in §§ 404.1520a(e)(1) and 416.920a(e)(1) would still be useful if we put them in terms that apply to our adjudication of cases involving mental disorders under these proposed listings and at other steps of the sequential evaluation process. For example, instead of providing that State agency disability examiners may assist medical and psychological consultants in preparing the PRTF, we would provide that State agency disability examiners may assist in reviewing the claim and preparing documents that contain the medical portion of the case review and any applicable RFC assessment. The proposed revisions are in §§ 404.1503, 404.1615, 416.903, and 416.1015 and would apply to both adults and children.

2. In current §§ 404.1520a(e)(3) and 416.920a(e)(3), we provide that, if an ALJ:

- Requires the services of a medical expert to assist in applying the PRT, but
- Such services are not available,

the ALJ may return the case to the State agency for completion of a PRTF under the provisions of §§ 404.941 and 416.1441. Although we would no longer have a PRT or PRTF under these proposed rules, we propose to include a provision in §§ 404.941 and 416.1441 that would let ALJs continue to ask State agency medical and psychological consultants to evaluate claims involving mental disorders when they need the services of a medical expert and no expert is available.

We would not keep the guidance in §§ 404.1520a(d)(1) and 416.920a(d)(1) about ratings that indicate that a mental disorder is “not severe” because we would no longer have the PRT and its rating system. We also believe that the guidance is unnecessary since it provides only that persons who have no limitations or only mild limitations probably have impairments that are “not severe.” This guidance only restates in language specific to mental disorders what our other rules already provide. See, for example, §§ 404.1520(c), 404.1521, 416.920(c), and 416.921 of our regulations.

If we remove §§ 404.1520a and 416.920a, we would also remove current 12.00I, “Technique for reviewing evidence in mental disorders claims to determine the level of impairment severity,” in the introductory text to the current listings.

### Other Proposed Changes

Throughout these proposed rules, we make nonsubstantive editorial changes to update medical terminology in the introductory text and the listings and to

make their structure and language simpler and clearer. We also designate all paragraphs in the proposed rules with letters or numbers to make it easier to refer to them, and provide headings for all of the major sections and many of the subsections.

We also propose to make a number of conforming changes in other body systems that would reflect the changes in the proposed mental disorders listings, specifically, the respiratory system for adults (3.00), multiple body systems for adults and children (10.00 and 110.00), neurological for adults (11.00), and immune disorders for children (114.00)<sup>50</sup> In addition, we propose to add a new section 111.00F to provide our policy for evaluating traumatic brain injury (TBI) in the childhood listings. The information is essentially the same as in current 11.00F.

Each of the current listings in 114.00—the immune disorders system for children—includes criteria that cross-refer to the functional criteria in current listings 112.02 and 112.12. We are proposing to remove these listing criteria without replacement. According to our data, we almost never use them, and in some cases, we have never used them. For example, from fiscal year (FY) 2003 through FY 2007, only two children were allowed under the functional listing for human immunodeficiency virus (HIV) infection at the initial level of adjudication. We added functional criteria to all of the other child immune system listings beginning in June 2008, but in FY 2009, only 13 children qualified at the initial level under those new listings.<sup>51</sup>

Under the current 114.00 listings, we use the functional criteria in the childhood mental disorders listings to evaluate both physical and mental limitations that result from immune

<sup>50</sup> Some of these changes would remove reference listings (or portions of reference listings) that cross-refer to the mental disorders listings. Reference listings are listings that are met by satisfying the criteria of other listings. The reference listings for mental disorders are redundant because we evaluate mental effects of impairments using the listings in 12.00 and 112.00. We have been removing reference listings from all of the body systems as we revise them, and the changes we are proposing in this NPRM are consistent with that approach. Examples of recent such changes include the “Revised Medical Criteria for Evaluating Digestive Disorders,” 72 FR 59398 (October 19, 2007), and the “Revised Medical Criteria for Evaluating Immune System Disorders,” 73 FR 14570 (March 18, 2008).

<sup>51</sup> We published the functional criteria for the other listings in the immune body system in March 2008, and the rules became effective June 16, 2008. 73 FR 14570. From June 16, 2008, through September 30, 2009, we found that only 21 children qualified under the immune listings containing functional criteria, including the HIV listing.

system disorders. We believe that, because of the nature of the changes we are proposing in these mental disorders listings, it would no longer be appropriate to incorporate the criteria in the childhood mental disorders listings by reference if we publish the proposed rules as final rules. Moreover, children with claims for SSI can qualify under our rules for functional equivalence to the listings, which consider their functional limitations in domains that we designed to cover all childhood physical and mental functioning. The very small number of children who qualify under the functional criteria in the immune disorders listings would still be able to qualify under our functional equivalence criteria.

We are not proposing a similar change to the adult listings for immune disorders in 14.00. Each of those listings also contains criteria for evaluating functioning, but we do not cross-refer to the adult mental disorders listings; rather, we include specific functional criteria within each of the adult listings. Also, we do not have functional equivalence rules for adults.

Finally, we propose to update a provision in § 416.934. Section 416.934 provides a list of impairment categories that employees in our field offices may use to make findings of presumptive disability in SSI claims without obtaining any medical evidence.<sup>52</sup> Section 416.934(h) applies to claimants who are at least 7 years old. It uses the outdated term “mental deficiency.” It also refers to allegations that a child “is unable to attend any type of school.”

We propose to revise § 416.934(h) to:

- Reduce the lower age limit from age 7 to age 4,
- Refer to ID/MR and other cognitive impairments, and
- Remove the statement about inability to attend school and replace it with a new requirement.

The proposed new requirement is an allegation of a complete inability to independently perform basic self-care activities (such as toileting, eating, dressing, or bathing) made by another person who files on behalf of the claimant. We based the proposed criterion on proposed listings 12.05A and 112.05A, but it is somewhat different than the listing criterion, which does not necessarily require a “complete” inability to perform basic self-care activities. We proposed this

<sup>52</sup> We may make SSI payments based on presumptive disability or presumptive blindness when there is a high degree of probability that we will find a claimant disabled or blind when we make our formal disability determination at the initial level of our administrative review process. 20 CFR 416.931.



criterion because the regulation section has a very narrow and specific purpose: to allow employees in our field offices, who do not make disability determinations and will not be reviewing medical evidence for these cases, to authorize presumptive disability payments while the State agency is determining whether the claimant is disabled.

We propose to reduce the lower age limit to age 4 because we believe that age 7 is too high, and age 4 is the lowest age at which we can confidently permit our field office employees to accept the allegation in the proposed rule.

These proposed rule changes apply only to our field office employees. State agencies will still be able to authorize presumptive disability payments, in appropriate cases, for children under age 4 and for children and adults who do not have a complete inability to perform basic self-care activities. Under § 416.933 of our regulations, which we are not proposing to change, State agencies may authorize presumptive disability payments whenever they determine that the evidence they already have reflects a high degree of probability that a person is disabled.

#### **What other projects are we doing to determine the requirements of work?**

These proposed rules include criteria that refer to the requirements of work. We are also conducting two long-term projects that we expect will help us to better determine the requirements of work. While the outcome of these projects may affect rules that we may propose in the future, we believe that these long-term projects do not affect our decision to proceed with these proposed rules now. We would welcome your comments regarding the proposed regulatory changes to the listing of mental impairments in light of the projects we have underway.

- We are working to develop an occupational information system (OIS), tailored to our disability programs, which will replace our use of the *Dictionary of Occupational Titles*. The goal of the research and development underway for the OIS Development Project is to provide occupational information that our adjudicators can use to evaluate disability claims at steps 4 and 5 of the sequential evaluation process. The OIS Development Project must conduct research regarding the requirements of work in terms of physical and mental-cognitive function that we consider in our residual functional capacity assessments of

disability claimants.<sup>53</sup> As the results of the OIS Development Project may inform our criteria regarding the physical and mental-cognitive functioning required to do substantial gainful activity, the research may also inform related criteria for gainful work articulated in our Listing of Impairments.

- Our evaluation of disability often involves both medical and functional criteria. The Clinical Research Center at the National Institutes of Health has been involved in extensive research concerning the impact of functional limitations on rehabilitation outcomes. Currently, we have an interagency agreement with the Clinical Research Center to explore the possibility of using International Classification of Functioning domains in predicting disability. Modern concepts of disability emphasize the gap between personal abilities and environmental demands. Therefore, it is crucial to characterize a claimant's functional abilities, work-related requirements, as well as key aspects of his or her workplace, home, and community environments in order to assess the potential for substantial gainful activity more comprehensively.

#### **What is our authority to make rules and set procedures for determining whether a person is disabled under the statutory definition?**

Under the Act, we have full power and authority to make rules and regulations, and to establish necessary and appropriate procedures to carry out such provisions. Sections 205(a), 702(a)(5), and 1631(d)(1).

#### **How long would these proposed rules be effective?**

If we publish these proposed rules as final rules, they will remain in effect for 5 years after the date they become effective, unless we extend them or revise and issue them again.

#### **Clarity of These Proposed Rules**

Executive Order 12866, as amended, requires each agency to write all rules

<sup>53</sup> To provide independent advice and recommendations on these plans and activities, we convened a discretionary advisory committee, the Occupational Information Development Advisory Panel (Panel), which was established under the Federal Advisory Committee Act of 1972, as amended. This Panel began meeting in February 2009 and delivered its first report in September 2009. Among other recommendations, this report recommends that we adopt specific domains of mental-cognitive functioning that are critical to the evaluation of a claim for disability benefits. These domains are different than those contained in this proposed rule. The Panel's report, in its entirety, can be accessed at <http://www.ssa.gov/oidap/index.htm>; the recommended mental-cognitive domains and data elements are located on pages 41 and 42 of this report.

in plain language. In addition to your substantive comments on these proposed rules, we invite your comments on how to make them easier to understand.

For example:

- Have we organized the material to suit your needs?
- Are the requirements in the rules clearly stated?
- Do the rules contain technical language or jargon that is not clear?
- Would a different format (grouping and order of sections, use of headings, paragraphing) make the rules easier to understand?
- Would more (but shorter) sections be better?
- Could we improve clarity by adding tables, lists, or diagrams?
- What else could we do to make the rules easier to understand?

#### **When will we start to use these rules?**

We will not use these rules until we evaluate public comments and publish final rules in the **Federal Register**. All final rules we issue include an effective date. We will continue to use our current rules until that date. If we publish final rules, we will include a summary of those relevant comments we received along with responses and an explanation of how we will apply the new rules.

#### **Regulatory Procedures**

##### *Executive Order 12866*

We have consulted with the Office of Management and Budget (OMB) and determined that these proposed rules meet the requirements for a significant regulatory action under Executive Order 12866. Thus, they were subject to OMB review.

We believe these proposed rules are not economically significant within the meaning of Executive Order 12866; however, we invite public comment on the cost impact of the rules.

##### *Regulatory Flexibility Act*

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

##### *Paperwork Reduction Act*

These rules do not create any new, or affect any existing, collections and, therefore, do not require Office of Management and Budget approval under the Paperwork Reduction Act.

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These references are included in the rulemaking record for these proposed rules and are available for inspection by interested persons by making arrangements with the contact person shown in this preamble.

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

## List of Subjects

### 20 CFR Part 404

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

### 20 CFR Part 416

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

### Michael J. Astrue,

Commissioner of Social Security.

For the reasons set out in the preamble, we propose to amend subparts J, P, and Q of part 404 and subparts I, J, and N of part 416 of

chapter III of title 20 of the Code of Federal Regulations as set forth below:

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

**Subpart J—[Amended]**

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

**Authority:** Secs. 201(j), 204(f), 205(a)–(b), (d)–(h), and (j), 221, 223(i), 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 401(j), 404(f), 405(a)–(b), (d)–(h), and (j), 421, 423(i), 425, and 902(a)(5)); sec. 5, Pub. L. 97–455, 96 Stat. 2500 (42 U.S.C. 405 note); secs. 5, 6(c)–(e), and 15, Pub. L. 98–460, 98 Stat. 1802 (42 U.S.C. 421 note); sec. 202, Pub. L. 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

2. Amend § 404.941 by revising paragraphs (b)(3) and (b)(4), and adding paragraph (b)(5) to read as follows:

**§ 404.941 Prehearing case review.**

- (b) \* \* \*
- (3) There is a change in the law or regulation;
- (4) There is an error in the file or some other indication that the prior determination may be revised; or
- (5) An administrative law judge requires the services of a medical expert to assist in reviewing a mental disorder(s), but such services are unavailable.

\* \* \* \* \*

**Subpart P—[Amended]**

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

**Authority:** Secs. 202, 205(a)–(b), and (d)–(h), 216(i), 221(a) and (i), 222(c), 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 405(a)–(b), and (d)–(h), 416(i), 421(a) and (i), 422(c), 423, 425, and 902(a)(5)); sec. 211(b), Pub. L. 104–193, 110 Stat. 2105, 2189, sec. 202, Pub. L. 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

4. Amend § 404.1503 by redesignating paragraph (e) as paragraph (e)(1) and adding a new paragraph (e)(2), to read as follows:

**§ 404.1503 Who makes disability and blindness determinations.**

- (e) \* \* \*
- (2) *Overall responsibility for evaluating mental impairments.* (i) In any case at the initial and reconsideration levels, except in cases in which a disability hearing officer makes the reconsideration determination, our medical or psychological consultant has overall responsibility for assessing the medical severity of your mental impairment(s).

The State agency disability examiner may assist in reviewing the claim and preparing documents that contain the medical portion of the case review and any applicable residual functional capacity assessment. However, our medical or psychological consultant must review and sign any document(s) that includes the medical portion of the case review and any applicable residual functional capacity assessment to attest that these documents are complete and that he or she is responsible for the content, including the findings of fact and any discussion of supporting evidence. When a disability hearing officer makes a reconsideration determination, the disability hearing officer has overall responsibility for assessing the medical severity of your mental impairment(s). The determination must document the disability hearing officer's pertinent findings and conclusions regarding the mental impairment(s).

(ii) At the administrative law judge hearing and Appeals Council levels, the administrative law judge or, if the Appeals Council makes a decision, the Appeals Council has overall responsibility for assessing the medical severity of your mental impairment(s). The written decision must incorporate the pertinent findings and conclusions of the administrative law judge or Appeals Council.

**§ 404.1520a [Removed]**

5. Remove § 404.1520a.
6. Amend appendix 1 to subpart P of part 404 as follows:
- a. Revise item 13 of the introductory text before part A.
- b. Revise the last sentence of section 3.00H of part A.
- c. Revise listing 3.10 of part A.
- d. Revise the fourth sentence of section 10.00A2 of part A.
- e. Revise the third sentence in the first undesignated paragraph of section 11.00E of part A.
- f. Add a new undesignated sixth paragraph to section 11.00E of part A.
- g. Revise the introductory paragraph of section 11.00F of part A of appendix 1.
- h. Revise 11.09 of part A.
- i. Revise 11.17 of part A.
- j. Revise 11.18 of part A.
- k. Revise section 12.00 of part A.
- l. Revise the fourth sentence of section 110.00A2 of part B.
- m. Add section 111.00F to part B.
- n. Revise section 112.00 of part B.
- o. Revise the first sentence of section 114.00D6e(ii), remove section 114.00I, and redesignate section 114.00J as section 114.00I in part B.
- p. Revise 114.02 and 114.03 of part B.

q. Remove the semicolon and the word “or” after section 114.04C2, add a period after section 114.04C2, and remove section 114.04D of part B.

r. Remove the word “or” after section 114.05D and remove section 114.05E of part B.

s. Revise 114.06 of part B.

t. Remove the word “or” after section 114.07B and remove section 114.07C of part B.

u. Remove the word “or” after section 114.08K and remove section 114.08L of part B.

v. Remove the word “or” after section 114.09C and remove section 114.09D of part B.

w. Revise 114.10 of part B.

The revisions read as follows:

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

\* \* \* \* \*

13. Mental Disorders (12.00 and 112.00): (Insert date 5 years from the effective date of the final rules).

\* \* \* \* \*

**Part A**

\* \* \* \* \*

**3.00 Respiratory System**

\* \* \* \* \*

H. *Sleep-related breathing disorders.* \* \* \* \* \*  
Mental disorders affecting cognition that result from sleep-related breathing disorders are evaluated under 12.02 (Dementia and amnesic and other cognitive disorders).

\* \* \* \* \*

**3.01 Category of Impairments, Respiratory System**

\* \* \* \* \*

3.10 *Sleep-related breathing disorders.* Evaluate under 3.09 (chronic cor pulmonale) or 12.02 (Dementia and amnesic and other cognitive disorders).

\* \* \* \* \*

**10.00 Impairments That Affect Multiple Body Systems**

A. *What impairment do we evaluate under this body system?*

\* \* \* \* \*

2. *What is Down syndrome?* \* \* \* \* \*  
Down syndrome is characterized by a complex of physical characteristics, delayed physical development, and intellectual disability/mental retardation (ID/MR). \* \* \* \* \*

\* \* \* \* \*

**11.00 Neurological**

\* \* \* \* \*

E. *Multiple sclerosis.* \* \* \* \* \*  
Paragraph B provides references to other listings for evaluating visual disorders caused by multiple sclerosis. \* \* \* \* \*

\* \* \* \* \*

We evaluate mental impairments associated with multiple sclerosis under 12.00.

\* \* \* \* \*

F. *Traumatic brain injury (TBI)*. We evaluate neurological impairments that result from TBI under 11.02, 11.03, or 11.04, as applicable. We evaluate mental impairments that result from TBI under 12.02.

\* \* \* \* \*  
 11.09 *Multiple sclerosis*. With:  
 \* \* \* \* \*

B. Visual disorder as described under the criteria in 2.02, 2.03, or 2.04; or

\* \* \* \* \*

11.17 *Degenerative disease not listed elsewhere, such as Huntington's disease, Friedreich's ataxia, and spino-cerebellar degeneration*. With disorganization of motor function as described in 11.04B.

\* \* \* \* \*

11.18 *Cerebral trauma*. Evaluate under 11.02, 11.03, or 11.04, as applicable.

## 12.00 Mental Disorders

A. *What are the listings, and what do they require?*

1. The listings for mental disorders are arranged in 10 categories: Dementia and amnesic and other cognitive disorders (12.02); schizophrenia and other psychotic disorders (12.03); mood disorders (12.04); intellectual disability/mental retardation (ID/MR) (12.05); anxiety disorders (12.06); somatoform disorders (12.07); personality disorders (12.08); autism spectrum disorders (12.10); other disorders usually first diagnosed in childhood or adolescence (12.11); and eating disorders (12.13).

2. Each listing is divided into three paragraphs, designated A, B, and C. Except for 12.05, the listing for ID/MR, your mental disorder must satisfy the requirements of paragraphs A and B or paragraphs A and C in the listing for your mental disorder. See 12.00A3 for the requirements for 12.05.

a. Paragraph A of each listing (except 12.05) requires you to show that you have a medically determinable mental disorder in the listing category. For example, for 12.03A, you must have evidence showing that you have schizophrenia or another medically determinable psychotic disorder. Paragraph A also includes a reference to the corresponding section of 12.00B that describes the listing category; for example, the reference in 12.03A is to 12.00B2, where we provide a general description of schizophrenia and other psychotic disorders and give examples of disorders in the category.

b. (i) Paragraph B of each listing (except 12.05) provides the criteria we use to evaluate the severity of your mental disorder. These criteria are the mental abilities a person uses to function in a work setting, and they apply to all of the listings. To satisfy the paragraph B criteria, your mental disorder must result in "marked" limitations of two or "extreme" limitation of one of the mental abilities in paragraph B (see 12.00C, D, and F).

(ii) When we refer to "paragraph B" or "the paragraph B criteria" in the introductory text of this body system, we mean the criteria in paragraph B of every mental disorders listing except 12.05.

c. (i) Paragraph C provides an alternative to the paragraph B criteria that we can use

to evaluate the severity of mental disorders except those under 12.05. To satisfy the paragraph C criteria, you must have a serious and persistent mental disorder under one of those listings that satisfies the criteria in both C1 and C2 (see 12.00E and F).

(ii) When we refer to "paragraph C" or "the paragraph C criteria" in the introductory text of this body system, we mean the criteria in paragraph C of every mental disorders listing except 12.05.

3. To meet 12.05, your ID/MR must satisfy 12.05A, B, or D, or you must have a combination of ID/MR and another "severe" physical or mental impairment that satisfies 12.05C.

B. *How do we describe the mental disorders listing categories?* In the following sections, we provide a brief description of the mental disorders included in each listing category, followed by examples of symptoms and signs that persons with disorders in each category may have. Except for 12.05, we also provide examples of common mental disorders diagnosed in each category; we do not provide examples for 12.05 because ID/MR is the only disorder covered by that listing. Although the evidence must show that you have a mental disorder in one of the listing categories, your mental disorder does not have to match one of the examples in this section. We will find that any mental disorder meets one of these mental disorders listings when it can be included in one of the listing categories and satisfies the other criteria of the appropriate listing.

### 1. Dementia and Amnesic and Other Cognitive Disorders (12.02)

a. These disorders are characterized by a clinically significant decline in cognitive functioning.

b. Symptoms and signs may include, but are not limited to, disturbances in memory, executive functioning (that is, higher-level cognitive processes; for example, regulating attention, planning, inhibiting responses, decisionmaking), psychomotor activity, visual-spatial functioning, language and speech, perception, insight, and judgment.

c. Examples of disorders in this category include the following.

(i) Dementia of the Alzheimer's type;  
 (ii) Vascular dementia;  
 (iii) Traumatic brain injury, or TBI (see also 11.00F); and

(iv) Dementia and amnesic or other cognitive disorders due to medications, toxins, or a general medical condition, such as human immunodeficiency virus infection, neurological disease (for example, multiple sclerosis, Parkinson's disease, Huntington's disease), or metabolic disease (for example, late-onset Tay-Sachs disease).

d. This category does not include mental disorders that are included in the listing categories for ID/MR (12.05), autism spectrum disorders (12.10), and other disorders usually first diagnosed in childhood or adolescence (12.11).

### 2. Schizophrenia and Other Psychotic Disorders (12.03)

a. These disorders are characterized by delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior, causing a clinically significant decline in functioning.

b. Symptoms and signs may include, but are not limited to, inability to initiate and persist in goal-directed activities, social withdrawal, flat or inappropriate affect, poverty of thought and speech, loss of interest or pleasure, disturbances of mood, odd beliefs and mannerisms, and paranoia.

c. Examples of disorders in this category include schizophrenia, schizoaffective disorder, delusional disorder, and psychotic disorder due to a general medical condition.

### 3. Mood Disorders (12.04)

a. These disorders are characterized by an irritable, depressed, elevated, or expansive mood, or by a loss of interest or pleasure in all or almost all activities, causing a clinically significant decline in functioning.

b. Symptoms and signs may include, but are not limited to, feelings of hopelessness or guilt, suicidal ideation, a clinically significant change in body weight or appetite, sleep disturbances, an increase or decrease in energy, psychomotor abnormalities, disturbed concentration, pressured speech, grandiosity, reduced impulse control, rapidly alternating moods, sadness, euphoria, and social withdrawal.

c. Examples of disorders in this category include major depressive disorder, the various types of bipolar disorders, cyclothymic disorder, dysthymic disorder, and mood disorder due to a general medical condition.

### 4. Intellectual Disability/Mental Retardation (ID/MR) (12.05)

a. This disorder is defined by significantly subaverage general intellectual functioning with significant deficits in adaptive functioning initially manifested before age 22.

b. Signs may include, but are not limited to, poor conceptual, social, and practical skills, and a tendency to be passive, placid, and dependent on others, or to be impulsive or easily frustrated. When we evaluate your adaptive functioning, we also consider the factors in 12.00F.

c. ID/MR is often demonstrated by evidence from the period before age 22. However, when we do not have evidence from that period, we will still find that you have ID/MR if we have evidence about your current functioning and the history of your impairment that is consistent with the diagnosis, and there is no evidence to indicate an onset after age 22.

d. We consider your IQ score to be "valid" when it is supported by the other evidence, including objective clinical findings, other clinical observations, and evidence of your day-to-day functioning that is consistent with the test score. If the IQ test provides more than one IQ score (for example, a verbal, performance, and full scale IQ in a Wechsler series test), we use the lowest score. When we consider your IQ score, we apply the rules in 12.00D4.

e. In 12.05C, the term "severe" has the same meaning as in §§ 404.1520(c) and 416.920(c). Your additional impairment(s) must cause more than a slight or minimal physical or mental functional limitation(s); it must significantly limit your physical or mental ability to do basic work activities, as we explain in those sections of our regulations

and §§ 404.1521 and 416.921. The limitation(s) must be separate from the limitations caused by your ID/MR; for example, limitation in your ability to respond appropriately to supervision and coworkers that result from another mental disorder or in your physical ability to walk, stand, or sit. If your additional impairment(s) is not "severe" as defined in our regulations, your ID/MR will not meet 12.05C even if your additional impairment(s) prevents you from doing your past work because of the unique features of that work.

f. Listing 12.05 is for ID/MR only. We evaluate other mental disorders that primarily affect cognition in the listing categories for dementia and amnesic and other cognitive disorders (12.02), autism spectrum disorders (12.10), or other disorders usually first diagnosed in childhood or adolescence (12.11), as appropriate.

#### 5. Anxiety Disorders (12.06)

a. These disorders are characterized by excessive anxiety, worry, apprehension, and fear, or by avoidance of feelings, thoughts, activities, objects, places, or persons.

b. Symptoms and signs may include, but are not limited to, restlessness, difficulty concentrating, hyper-vigilance, muscle tension, sleep disturbance, fatigue, panic attacks, obsessions and compulsions, constant thoughts and fears about safety, and frequent somatic complaints. Symptoms and signs associated with trauma may include recurrent intrusive recollections of a traumatic event, and acting or feeling as if the traumatic event were recurring.

c. Examples of disorders in this category include panic disorder, phobic disorder, obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), generalized anxiety disorder, and anxiety disorder due to a general medical condition.

#### 6. Somatoform Disorders (12.07)

a. These disorders are characterized by physical symptoms or deficits that are not intentionally produced or feigned, and that, following clinical investigation, cannot be fully explained by a general medical condition, another mental disorder, the direct effects of a substance, or a culturally sanctioned behavior or experience.

b. Symptoms and signs may include, but are not limited to, pain and other abnormalities of sensation, gastrointestinal symptoms, fatigue, abnormal motor movement, pseudoseizures, and pseudoneurological symptoms, such as blindness or deafness.

c. Examples of disorders in this category include somatization disorder, conversion disorder, body dysmorphic disorder, and pain disorder associated with psychological factors.

#### 7. Personality Disorders (12.08)

a. These disorders are characterized by an enduring, inflexible, pervasive, and maladaptive pattern of inner experience and behavior that causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, and that has an onset in adolescence or early adulthood.

b. Symptoms and signs may include, but are not limited to, patterns of distrust,

suspiciousness, and odd beliefs; social detachment, discomfort, or avoidance; hypersensitivity to negative evaluation; an excessive need to be taken care of; difficulty making independent decisions; a preoccupation with orderliness, perfectionism, and control; grandiosity; inappropriate and intense anger; self-mutilating behaviors; and recurrent suicidal threats, gestures, or attempts.

c. Examples of disorders in this category include paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, dependent personality disorder, borderline personality disorder, and obsessive-compulsive personality disorder.

#### 8. Autism Spectrum Disorders (12.10)

a. These disorders are characterized by qualitative deficits in the development of reciprocal social interaction, verbal and nonverbal communication skills, and symbolic or imaginative activity; restricted repetitive and stereotyped patterns of behavior, interests, and activities; and a history of early stagnation of skill acquisition or loss of previously acquired skills.

b. Symptoms and signs may include, but are not limited to, abnormalities and unevenness in the development of cognitive skills; unusual responses to sensory stimuli; and behavioral difficulties, including hyperactivity, short attention span, impulsivity, aggressiveness, or self-injurious actions.

c. Examples of disorders in this category include autistic disorder, Asperger's disorder, and pervasive developmental disorder (PDD).

d. This category does not include mental disorders that are included in the listing categories for dementia and amnesic and other cognitive disorders (12.02), ID/MR (12.05), and other disorders usually first diagnosed in childhood or adolescence (12.11).

#### 9. Other Disorders Usually First Diagnosed in Childhood or Adolescence (12.11)

a. These disorders are characterized by onset during childhood or adolescence, although sometimes they are not diagnosed until adulthood.

b. Symptoms and signs may include, but are not limited to, underlying abnormalities in cognitive processing (for example, deficits in learning and applying verbal or nonverbal information, visual perception, memory, or a combination of these), deficits in attention or impulse control, low frustration tolerance, excessive or poorly planned motor activity, difficulty with organizing (time, space, materials, or tasks), repeated accidental injury, and deficits in social skills.

Symptoms and signs specific to tic disorders include sudden, rapid, recurrent, non-rhythmic, stereotyped motor movement or vocalization; mood lability; and obsessions and compulsions.

c. Examples of disorders in this category include learning disorders, attention-deficit/hyperactivity disorder, and tic disorders, such as Tourette syndrome, chronic motor or vocal tic disorder, and transient tic disorder.

d. This category does not include mental disorders that are included in the listing categories for dementia and amnesic and

other cognitive disorders (12.02), ID/MR (12.05), and autism spectrum disorders (12.10).

#### 10. Eating Disorders (12.13)

a. These disorders are characterized by disturbances in eating behavior and preoccupation with, and excessive self-evaluation of, body weight and shape.

b. Symptoms and signs may include, but are not limited to, refusal to maintain a minimally normal weight or a minimally normal body mass index (BMI); recurrent episodes of binge eating and behavior intended to prevent weight gain, such as self-induced vomiting, excessive exercise, or misuse of laxatives; mood disturbances, social withdrawal, or irritability; amenorrhea; dental problems; abnormal laboratory findings; and cardiac abnormalities.

c. Examples of disorders in this category include anorexia nervosa and bulimia nervosa.

*C. What are the paragraph B criteria? The paragraph B criteria are the mental abilities a person uses to function in a work setting. They are the abilities to: Understand, remember, and apply information (paragraph B1); interact with others (paragraph B2); concentrate, persist, and maintain pace (paragraph B3); and manage oneself (paragraph B4). In this section, we provide basic definitions of the four paragraph B mental abilities and some examples of how a person may use these mental abilities to function in a work setting. In 12.00D, we explain how we rate the severity of limitations in the paragraph B mental abilities under these listings.*

1. *Understand, remember, and apply information (paragraph B1).* This is the ability to acquire, retain, integrate, access, and use information to perform work activities. You use this mental ability when, for example, you follow instructions, provide explanations, and identify and solve problems.

2. *Interact with others (paragraph B2).* This is the ability to relate to and work with supervisors, co-workers, and the public. You use this mental ability when, for example, you cooperate, handle conflicts, and respond to requests, suggestions, and criticism.

3. *Concentrate, persist, and maintain pace (paragraph B3).* This is the ability to focus attention on work activities and to stay on task at a sustained rate. You use this mental ability when, for example, you concentrate, avoid distractions, initiate and complete activities, perform tasks at an appropriate and consistent speed, and sustain an ordinary routine.

4. *Manage oneself (paragraph B4).* This is the ability to regulate your emotions, control your behavior, and maintain your well-being in a work setting. You use this mental ability when, for example, you cope with your frustration and stress, respond to demands and changes in your environment, protect yourself from harm and exploitation by others, inhibit inappropriate actions, take your medications, and maintain your physical health, hygiene, and grooming.

*D. How do we use the paragraph B mental abilities to evaluate your mental disorder?*

### 1. General

a. When we rate your limitations using the paragraph B mental abilities, we consider only limitations you have because of your mental disorder.

b. To do most kinds of work, a person is expected to use his or her mental abilities independently, appropriately, effectively, and on a sustained basis.

c. Marked or extreme limitation of a paragraph B mental ability reflects the overall degree to which your mental disorder interferes with your using that ability independently, appropriately, effectively, and on a sustained basis in a work setting. It does not necessarily reflect a specific type or number of activities, including activities of daily living, that you have difficulty doing. In addition, no single piece of information (including test scores) can establish whether you have marked or extreme limitation of a paragraph B mental ability. (See 12.00D4.)

d. Marked or extreme limitation of a paragraph B mental ability also reflects the kind and extent of supports you receive and the characteristics of any highly structured setting in which you spend your time that enable you to function as you do. The more extensive the supports or the more structured the setting you need to function, the more limited we will find you to be. (See 12.00F.)

### 2. What We Mean by "Marked" Limitation

a. *Marked limitation* of a paragraph B mental ability means that the symptoms and signs of your mental disorder interfere *seriously* with your using that mental ability independently, appropriately, effectively, and on a sustained basis to function in a work setting. Although we do not require the use of such a scale, marked would be the fourth point on a five-point rating scale consisting of no limitation, slight limitation, moderate limitation, marked limitation, and extreme limitation.

b. Although we do not require standardized test scores to determine whether you have marked limitations, we will generally find that you have marked limitation of a paragraph B mental ability when you have a valid score that is at least two, but less than three, standard deviations below the mean on an individually administered standardized test designed to measure that ability and the evidence shows that your functioning over time is consistent with the score. (See also 12.00D4.)

c. Marked limitation is also the equivalent of the level of limitation we would expect to find on standardized testing with scores that are at least two, but less than three, standard deviations below the mean.

### 3. What We Mean by "Extreme" Limitation

a. *Extreme limitation* of a paragraph B mental ability means that the symptoms and signs of your mental disorder interfere *very seriously* with your using that mental ability independently, appropriately, effectively, and on a sustained basis to function in a work setting. Although we do not require the use of such a scale, extreme would be the last point on a five-point rating scale consisting of no limitation, slight limitation, moderate limitation, marked limitation, and extreme limitation.

b. Although we do not require standardized test scores to determine whether you have extreme limitations, we will generally find that you have extreme limitation of a paragraph B mental ability when you have a valid score that is at least three standard deviations below the mean on an individually administered standardized test designed to measure that ability and the evidence shows that your functioning over time is consistent with the score. (See also 12.00D4.)

c. "Extreme" is the rating we give to the worst limitations; however, it does not necessarily mean a total lack or loss of ability to function. It is the equivalent of the level of limitation we would expect to find on standardized testing with scores that are at least three standard deviations below the mean.

### 4. How We Consider Your Test Results

a. We do not rely on any IQ score or other test result alone. We consider your test scores together with the other information we have about how you use the mental abilities described in the paragraph B criteria in your day-to-day functioning.

b. We may find that you have "marked" or "extreme" limitation when you have a test score that is slightly higher than the levels we provide in 12.00D2 and D3 if other information in your case record shows that your functioning in day-to-day activities is seriously or very seriously limited. We will not find that you have "marked" or "extreme" limitation in your ability to understand, remember, and apply information (or in any other ability measured by a standardized test) unless you have evidence demonstrating that your functioning is consistent with such a limitation.

c. Generally, we will not find that a test result is valid for our purposes when the information we have about your functioning is of the kind typically used by medical professionals to determine that the test results are not the best measure of your day-to-day functioning. If there is a material inconsistency between your test results and other information in your case record, we will try to resolve it. We use the following guidelines when we consider your test scores:

(i) The interpretation of the test is primarily the responsibility of the professional who administered the test. The narrative report that accompanies the test results should specify whether the results are deemed to be valid; that is, whether they are consistent with your medical and developmental history and information about your day-to-day functioning.

(ii) It is our responsibility to ensure that the evidence in your case record is complete and to resolve any material inconsistencies in the evidence. In some cases, we will be able to resolve an inconsistency with the information already in your case record. In others, we may need to request additional information; for example, by recontacting your medical source(s), by purchasing a consultative examination, or by questioning persons who are familiar with your day-to-day functioning.

*E. What are the paragraph C criteria, and how do we use them to evaluate your mental disorder?*

1. *General.* We use the paragraph C criteria as an alternative to paragraph B to evaluate "serious and persistent mental disorders" under every mental disorders listing except 12.05. We can use the paragraph C criteria without first considering whether your mental disorder satisfies the paragraph B criteria.

#### 2. *Paragraph C criteria.*

a. To meet the paragraph C criteria, you must have a medically documented history, over a period of at least 1 year, of the existence of a serious and persistent mental disorder. Your mental disorder must also satisfy the criteria in C1 and C2.

b. *The criterion in C1* is satisfied when the evidence shows that continuing treatment, psychosocial support(s), or a highly structured setting(s) diminishes the symptoms and signs of your mental disorder. (See 12.00F.)

c. *The criterion in C2* is satisfied when the evidence shows that you have achieved only marginal adjustment despite your diminished symptoms and signs. "Marginal adjustment" means that your adaptation to the requirements of daily living and your environment is fragile; that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life. Changes or increased demands would likely lead to an exacerbation of your symptoms and signs and to deterioration in your functioning; for example, you would be unable to function outside a highly structured setting or outside your home. Similarly, because of the nature of your mental disorder, you could experience episodes of deterioration that require you to be hospitalized or absent from work, making it difficult for you to sustain work activity over time.

*F. How do we consider psychosocial supports, highly structured settings, and treatment when we evaluate your functioning?*

1. *Psychosocial supports and highly structured settings* may help you to function by reducing the demands made on you. However, your ability to function in settings (including your own home) that are less demanding, more structured, or more supportive than those in which persons typically work does not necessarily show how you would function in a work setting under the stresses of a normal workday and workweek on a sustained basis. Therefore, we will consider the kind and extent of supports you receive and the characteristics of any structured setting in which you spend your time when we evaluate the effect of your mental disorder on your functioning and rate the limitation of your mental abilities (see 12.00D).

#### 2. *Examples of psychosocial supports and highly structured settings.*

a. You need family members or other persons to monitor your daily activities and to help you function; for example, you need family members to remind you to eat, to shop for you and pay your bills, to administer your medications, or to change their work hours so you are never home alone.

b. You participate in a special education program that teaches you daily living and vocational skills (*see* 12.00G4).

c. You participate in a psychosocial rehabilitation program, such as a day treatment or clubhouse program, in which you receive training in entry-level work skills (*see* 12.00G4).

d. You participate in a sheltered, supported, or transitional work program, or in a competitive employment setting with the help of a job coach or an accommodating supervisor (*see* 12.00G4).

e. You receive treatment in a day program at a hospital, community treatment program, or other daily outpatient program.

f. You live in a group home, halfway house, or semi-independent living program with a counselor or resident supervisor who is there 24 hours a day.

g. You live in a hospital or other institution with 24-hour care.

h. You live alone and do not receive any psychosocial support(s); however, you have created a highly structured environment by eliminating all but minimally necessary contact with the world outside your living space.

### 3. Treatment.

a. With treatment, such as medications and psychotherapy, you may not only have your symptoms and signs reduced, but may be able to function well enough to work.

b. Treatment may not resolve all of the functional limitations that result from your mental disorder, and the medications you take or other treatment you receive for your disorder may cause side effects that affect your mental or physical functioning; for example, you may experience drowsiness, blunted affect, or abnormal involuntary movements.

c. We will consider the effect of any treatment on your functioning when we evaluate your mental disorder under these listings.

### G. What evidence do we need to evaluate your mental disorder?

1. *General.* We need evidence to assess the existence and severity of your mental disorder and its effects on your ability to function in a work setting. Although we always need evidence from an acceptable medical source, the individual facts of your case will determine the extent of that evidence and what evidence, if any, we need from other sources. For our basic rules on evidence, *see* §§ 404.1512, 404.1513, 416.912, and 416.913. For our rules on evidence about a person's symptoms, *see* §§ 404.1529 and 416.929.

2. *Evidence from medical sources.* We will consider all relevant medical evidence about your mental disorder from your physician, psychologist, and other medical sources. Other medical sources include health care providers, such as physician assistants, nurses, licensed clinical social workers, and therapists. These other medical sources can be very helpful in providing evidence to assess the severity of your mental disorder and the resulting limitation in functioning, especially if they see you regularly. Evidence from medical sources may include:

- a. Your reported symptoms.
- b. Your medical, psychiatric, and psychological history.

c. The results of physical or mental status examinations or other clinical findings.

d. Psychological testing, imaging studies, or other laboratory findings.

e. Your diagnosis.

f. The type, dosage, frequency, duration, and beneficial effects of medications you receive.

g. The type, frequency, duration, and beneficial effects of therapy or counseling you receive.

h. Any side effects of medication or other treatment that limit your ability to function (*see* 12.00F).

i. Your clinical course, including changes in your medication, therapy, or counseling and the time required for therapeutic effectiveness.

j. Observations and descriptions of how you function.

k. Any psychosocial support(s) you receive or highly structured setting(s) in which you are involved (*see* 12.00F).

l. Any sensory, motor, or speaking abnormalities or information about your cultural background (for example, language differences, customs) that may affect an evaluation of your mental disorder.

m. The expected duration of your symptoms and signs and their effects on your ability to function in a work setting over time.

3. *Evidence from you and persons who know you.* We will ask you to describe your symptoms and your limitations if you are able to do so, and we will use that information to help us determine whether you are disabled. We will also consider information from persons who can describe how you usually function from day to day when we need it to show the severity of your mental disorder and how it affects your ability to function. This information may include, but is not limited to, information from your family, other caregivers, friends, neighbors, or clergy. We will consider your statements and the statements of other persons to determine if they are consistent with the medical and other evidence we have.

### 4. Evidence from school, vocational training, work, and work-related programs.

a. If you have recently attended or are still attending school and have received or are receiving special education services, we will consider information from your school sources when we need it to show the severity of your mental disorder and how it affects your ability to function. This information may include, but is not limited to, Individualized Education Programs (IEPs), education records, therapy progress notes, and information from your teachers about how you function in their classrooms and about any special services or accommodations you receive at school.

b. If you recently attended or are still attending vocational training classes or if you have attempted to work or are working now, we will consider information from your training program or employer when we need it to show the severity of your mental disorder and how it affects your ability to function. This information may include, but is not limited to, training or work evaluations, modifications to your work

duties or work schedule, and any special supports or accommodations you have required or now require in order to work. If you have worked or are working through a community mental health program, a sheltered work program, a supported work program, a rehabilitation program, or a transitional employment program, we will consider the type and degree of support you have received or are receiving in order to work.

5. *Evidence from psychological and psychiatric measures.* We will consider the results from psychological and psychiatric measures together with all the other evidence in your case record. Results from these measures are only part of the evidence we use in our overall disability evaluation; we will not use these results alone to decide whether you are disabled. (*See* 12.00D4.)

### 6. Need for longitudinal evidence.

a. Many persons with mental disorders experience periods of worsening of the symptoms and signs of their mental disorders (exacerbations) and periods of improvement of their symptoms and signs (remissions). Exacerbations may make it difficult for you to sustain employment. Therefore, we generally will consider how you function longitudinally; that is, over time. We will not find that you are able to work solely because you have a period(s) of remission, or that you are disabled solely because you have an exacerbation(s) of your mental disorder. We will consider how often you have remissions and exacerbations and how long they last, what causes your mental disorder to improve or worsen, and any other information that is relevant to our determination about how you function over time. We will consider longitudinal evidence from relevant sources over a sufficient period to establish the severity of your mental disorder over time.

b. If you have a serious mental disorder, you will probably have evidence of its effects on your functioning over time, even if you do not have an ongoing relationship with the medical community. For example, family members, friends, adult day-care providers, teachers, neighbors, former employers, social workers, peer specialists, mental health clinics, emergency shelters, law enforcement, or government agencies may be familiar with your mental health history.

c. You may function differently and appear more or less limited in an unfamiliar or one-time situation, such as a consultative examination, than is indicated by other information about your functioning over time. Your ability to function during a time-limited mental status examination or psychological testing, or in another unfamiliar or one-time situation, does not necessarily show how you will be able to function in a work setting under the stresses of a normal workday and workweek on a sustained basis.

d. Working involves many factors and demands that can be stressful to persons with mental disorders; for example, the specific work activities involved, the physical work environment, the work schedule or routine, and the social interactions and relationships in the workplace. Stress may be caused, for example, by the demands of getting to work regularly, having your performance

supervised, or remaining in the workplace for a full day.

(i) Your reaction to stress associated with the demands of work may be different from another person's; that is, the symptoms and signs of your mental disorder may be more or less affected by stress than those of another person with the same mental disorder or another mental disorder.

(ii) We will consider evidence from all sources about the effects of stress on your mental abilities, including any evidence pertinent to the effects of work-related stress. We will also take into consideration what, if any, psychosocial support(s) or structure you would need when you experience work-related stress (see 12.00F).

*H. How do we evaluate substance use disorders?*

If we find that you are disabled and there is medical evidence in your case record establishing that you have a substance use disorder, we will determine whether your substance use disorder is a contributing factor material to the determination of disability. (See §§ 404.1535 and 416.935.)

*I. How do we evaluate mental disorders that do not meet one of the mental disorders listings?*

1. These listings include only examples of mental disorders that we consider severe enough to prevent you from doing any gainful activity. If your severe mental disorder does not meet the criteria of any of these listings, we will also consider whether you have an impairment(s) that meets the criteria of a listing in another body system. You may have a separate other impairment(s) or a physical impairment(s) that is secondary to your mental disorder. For example, if you have an eating disorder and develop a cardiovascular impairment because of it, we will evaluate your cardiovascular impairment under the listings for the cardiovascular body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. (See §§ 404.1526 and 416.926.)

3. If your impairment(s) does not meet or medically equal a listing, you may or may not have the residual functional capacity to engage in substantial gainful activity. (See §§ 404.1545 and 416.945.) In that situation, we proceed to the fourth, and if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920. When we assess your residual functional capacity, we consider all of your physical and mental limitations. If you have limitations in your ability to perform work-related physical activities that are secondary to your mental disorder, we will consider them when we assess your residual functional capacity. For example, limitations in walking or standing due to the side effects of medication you take to treat your mental disorder may affect your residual functional capacity for work requiring physical exertion. When we decide whether you continue to be disabled, we use the rules in §§ 404.1594 and 416.994.

**12.01 Category of Impairments, Mental Disorders**

12.02 *Dementia and Amnesic and Other Cognitive Disorders*, with both A and B or both A and C.

A. A medically determinable mental disorder in this category (see 12.00B1).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (see 12.00C1).
2. Ability to interact with others (see 12.00C2).
3. Ability to concentrate, persist, and maintain pace (see 12.00C3).
4. Ability to manage oneself (see 12.00C4).

OR

C. A serious and persistent mental disorder in this category (see 12.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 12.00E2c.

12.03 *Schizophrenia and Other Psychotic Disorders*, with both A and B or both A and C.

A. A medically determinable mental disorder in this category (see 12.00B2).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (see 12.00C1).
2. Ability to interact with others (see 12.00C2).
3. Ability to concentrate, persist, and maintain pace (see 12.00C3).
4. Ability to manage oneself (see 12.00C4).

OR

C. A serious and persistent mental disorder in this category (see 12.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 12.00E2c.

12.04 *Mood Disorders*, with both A and B or both A and C.

A. A medically determinable mental disorder in this category (see 12.00B3).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (see 12.00C1).
2. Ability to interact with others (see 12.00C2).
3. Ability to concentrate, persist, and maintain pace (see 12.00C3).
4. Ability to manage oneself (see 12.00C4).

OR

C. A serious and persistent mental disorder in this category (see 12.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*

2. Marginal adjustment, as described in 12.00E2c.

12.05 *Intellectual Disability/Mental Retardation (ID/MR)* satisfying A, B, C, or D.

A. ID/MR as defined in 12.00B4, with mental incapacity evidenced by dependence upon others for personal needs (for example, toileting, eating, dressing, or bathing) and an inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded.

OR

B. ID/MR as defined in 12.00B4, with a valid IQ score of 59 or less (as defined in 12.00B4d) on an individually administered standardized test of general intelligence having a mean of 100 and a standard deviation of 15 (see 12.00D4).

OR

C. ID/MR as defined in 12.00B4, with a valid IQ score of 60 through 70 (as defined in 12.00B4d) on an individually administered standardized test of general intelligence having a mean of 100 and a standard deviation of 15 (see 12.00D4) and with another "severe" physical or mental impairment (see 12.00B4e).

OR

D. ID/MR as defined in 12.00B4, with a valid IQ score of 60 through 70 (as defined in 12.00B4d) on an individually administered standardized test of general intelligence having a mean of 100 and a standard deviation of 15 (see 12.00D4), resulting in *marked* limitation of at least two of the following mental abilities:

1. Ability to understand, remember, and apply information (see 12.00C1).
2. Ability to interact with others (see 12.00C2).
3. Ability to concentrate, persist, and maintain pace (see 12.00C3).
4. Ability to manage oneself (see 12.00C4).

12.06 *Anxiety Disorders*, with both A and B or both A and C.

A. A medically determinable mental disorder in this category (see 12.00B5).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (see 12.00C1).
2. Ability to interact with others (see 12.00C2).
3. Ability to concentrate, persist, and maintain pace (see 12.00C3).
4. Ability to manage oneself (see 12.00C4).

OR

C. A serious and persistent mental disorder in this category (see 12.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 12.00E2c.

12.07 *Somatoform Disorders*, with both A and B or both A and C.

A. A medically determinable mental disorder in this category (see 12.00B6).

AND



B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (*see* 12.00C1).
2. Ability to interact with others (*see* 12.00C2).
3. Ability to concentrate, persist, and maintain pace (*see* 12.00C3).
4. Ability to manage oneself (*see* 12.00C4).

OR

C. A serious and persistent mental disorder in this category (*see* 12.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 12.00E2c.

12.08 *Personality Disorders*, with both A and B or both A and C.

A. A medically determinable mental disorder in this category (*see* 12.00B7).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (*see* 12.00C1).
2. Ability to interact with others (*see* 12.00C2).
3. Ability to concentrate, persist, and maintain pace (*see* 12.00C3).
4. Ability to manage oneself (*see* 12.00C4).

OR

C. A serious and persistent mental disorder in this category (*see* 12.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 12.00E2c.

12.10 *Autism Spectrum Disorders*, with both A and B or both A and C.

A. A medically determinable mental disorder in this category (*see* 12.00B8).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (*see* 12.00C1).
2. Ability to interact with others (*see* 12.00C2).
3. Ability to concentrate, persist, and maintain pace (*see* 12.00C3).
4. Ability to manage oneself (*see* 12.00C4).

OR

C. A serious and persistent mental disorder in this category (*see* 12.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 12.00E2c.

12.11 *Other Disorders Usually First Diagnosed in Childhood or Adolescence*, with both A and B or both A and C.

A. A medically determinable mental disorder in this category (*see* 12.00B9).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (*see* 12.00C1).
2. Ability to interact with others (*see* 12.00C2).
3. Ability to concentrate, persist, and maintain pace (*see* 12.00C3).
4. Ability to manage oneself (*see* 12.00C4).

OR

C. A serious and persistent mental disorder in this category (*see* 12.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 12.00E2c.

12.13 *Eating Disorders*, with both A and B or both A and C.

A. A medically determinable mental disorder in this category (*see* 12.00B10).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (*see* 12.00C1).
2. Ability to interact with others (*see* 12.00C2).
3. Ability to concentrate, persist, and maintain pace (*see* 12.00C3).
4. Ability to manage oneself (*see* 12.00C4).

OR

C. A serious and persistent mental disorder in this category (*see* 12.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 12.00E2c.

\* \* \* \* \*

**Part B**

\* \* \* \* \*

**110.00 Impairments That Affect Multiple Body Systems**

A. *What kinds of impairments do we evaluate under this body system?*

\* \* \* \* \*

2. *What is Down syndrome?* \* \* \* Down syndrome is characterized by a complex of physical characteristics, delayed physical development, and intellectual disability/mental retardation (ID/MR). \* \* \*

\* \* \* \* \*

**111.00 Neurological**

\* \* \* \* \*

F. *Traumatic brain injury (TBI)*.

1. We evaluate neurological impairments that result from TBI under 111.02, 111.03, 111.06, and 111.09, as applicable. We evaluate mental impairments that result from TBI under 112.02.

2. TBI may result in neurological and mental impairments with a wide variety of posttraumatic symptoms and signs. The rate and extent of recovery can be highly variable and the long-term outcome may be difficult to predict in the first few months post-injury. Generally, the neurological impairment(s) will stabilize more rapidly than any mental impairment. Sometimes, a mental impairment may appear to improve immediately following TBI and then worsen,

or, conversely, may appear much worse initially but improve after a few months. Therefore, the mental findings immediately following TBI may not reflect the actual severity of your mental impairment(s). The actual severity of a mental impairment may not become apparent until 6 months post-injury.

3. In some cases, evidence of a profound neurological impairment is sufficient to permit a finding of disability within 3 months post-injury. If a finding of disability within 3 months post-injury is not possible based on any neurological impairment(s), we will defer adjudication of the claim until we obtain evidence of your neurological or mental impairments at least 3 months post-injury. If a finding of disability still is not possible at that time, we will again defer adjudication of the claim until we obtain evidence at least 6 months post-injury. At that time, we will fully evaluate any neurological and mental impairments and adjudicate the claim.

\* \* \* \* \*

**112.00 Mental Disorders**

A. *What are the mental disorders listings for children age 3 to the attainment of age 18, and what do they require?* (*See* 112.00I for the rules on developmental disorders in children from birth to age 3.)

1. The listings for mental disorders are arranged in 10 categories: Dementia and amnesic and other cognitive disorders (112.02); schizophrenia and other psychotic disorders (112.03); mood disorders (112.04); intellectual disability/mental retardation (ID/MR) (112.05); anxiety disorders (112.06); somatoform disorders (112.07); personality disorders (112.08); autism spectrum disorders (112.10); other disorders usually first diagnosed in childhood or adolescence (112.11); and eating disorders (112.13).

2. Each listing is divided into three paragraphs, designated A, B, and C. Except for 112.05, the listing for ID/MR, your mental disorder must satisfy the requirements of paragraphs A and B or paragraphs A and C in the listing for your mental disorder. *See* 112.00A3 for the requirements for 112.05.

a. Paragraph A of each listing (except 112.05) requires you to show that you have a medically determinable mental disorder in the listing category. For example, for 112.06A, you must have evidence showing that you have an anxiety disorder, such as obsessive-compulsive disorder or generalized anxiety disorder. Paragraph A also includes a reference to the corresponding section of 112.00B that describes the listing category; for example, the reference in 112.06A is to 112.00B5, where we provide a general description of anxiety disorders and give examples of disorders in the category.

b. (i) Paragraph B of each listing (except 112.05) provides the criteria we use to evaluate the severity of your mental disorder. These criteria are the mental abilities a child uses to do age-appropriate activities, and they apply to all of the listings. To satisfy the paragraph B criteria, your mental disorder must result in "marked" limitations of two or "extreme" limitation of one of the mental abilities in paragraph B (*see* 112.00C, D, and F).

(ii) When we refer to “paragraph B” or “the paragraph B criteria” in the introductory text of this body system, we mean the criteria in paragraph B of every mental disorders listing except 112.05.

c. (i) Paragraph C provides an alternative to the paragraph B criteria that we can use to evaluate the severity of mental disorders except those under 112.05. To satisfy the paragraph C criteria, you must have a serious and persistent mental disorder under one of those listings that satisfies the criteria in both C1 and C2 (*see* 112.00E and F).

(ii) When we refer to “paragraph C” or “the paragraph C criteria” in the introductory text of this body system, we mean the criteria in paragraph C of every mental disorders listing except 112.05.

3. To meet 112.05, your ID/MR must satisfy 112.05A, B, or D, or you must have a combination of ID/MR and another “severe” physical or mental impairment that satisfies 112.05C.

B. *How do we describe the mental disorders listing categories for children age 3 to the attainment of age 18?* In the following sections, we provide a brief description of the mental disorders included in each listing category, followed by examples of symptoms and signs that children with disorders in each category may have. Except for 112.05, we also provide examples of mental disorders diagnosed in each category; we do not provide examples for 112.05 because ID/MR is the only disorder covered by that listing. Although the evidence must show that you have a mental disorder in one of the listing categories, your mental disorder does not have to match one of the examples in this section. We will find that any mental disorder meets one of these mental disorders listings when it can be included in one of the listing categories and satisfies the other criteria of the appropriate listing.

#### 1. Dementia and Amnesic and Other Cognitive Disorders (112.02)

a. These disorders are characterized by a clinically significant decline in cognitive functioning.

b. Symptoms and signs may include, but are not limited to, disturbances in memory, executive functioning (that is, higher-level cognitive processes; for example, regulating attention, planning, inhibiting responses, decisionmaking), psychomotor activity, visual-spatial functioning, language and speech, perception, insight, and judgment.

c. Examples of disorders in this category include dementia and amnesic or other cognitive disorders due to medications, toxins, or a general medical condition, such as human immunodeficiency virus infection, neurological disease (for example, multiple sclerosis), or metabolic disease (for example, lysosomal storage disease, late-onset Tay-Sachs disease); and traumatic brain injury, or TBI (*see also* 111.00F).

d. This category does not include mental disorders that are included in the listing categories for ID/MR (112.05), autism spectrum disorders (112.10), and other disorders usually first diagnosed in childhood or adolescence (112.11).

#### 2. Schizophrenia and Other Psychotic Disorders (112.03)

a. These disorders are characterized by delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior, causing a clinically significant decline in functioning.

b. Symptoms and signs may include, but are not limited to, inability to initiate and persist in goal-directed activities, social withdrawal, flat or inappropriate affect, poverty of thought and speech, loss of interest or pleasure, disturbances of mood, odd beliefs and mannerisms, and paranoia.

c. Examples of disorders in this category include schizophrenia, schizoaffective disorder, delusional disorder, and psychotic disorder due to a general medical condition.

#### 3. Mood Disorders (112.04)

a. These disorders are characterized by an irritable, depressed, elevated, or expansive mood, or by a loss of interest or pleasure in all or almost all activities, causing a clinically significant decline in functioning.

b. Symptoms and signs may include, but are not limited to, feelings of hopelessness or guilt, suicidal ideation, a clinically significant change in body weight or appetite, sleep disturbances, an increase or decrease in energy, psychomotor abnormalities, disturbed concentration, pressured speech, grandiosity, reduced impulse control, rapidly alternating moods, sadness, euphoria, and social withdrawal. Depending on a child's age and developmental stage, certain features, such as somatic complaints, irritability, anger, aggression, and social withdrawal may be more commonly present than others.

c. Examples of disorders in this category include major depressive disorder, the various types of bipolar disorders, cyclothymic disorder, dysthymic disorder, and mood disorder due to a general medical condition.

#### 4. Intellectual Disability/Mental Retardation (ID/MR) (112.05)

a. This disorder is defined by significantly subaverage general intellectual functioning with significant deficits in adaptive functioning.

b. Signs may include, but are not limited to, poor conceptual, social, and practical skills, and a tendency to be passive, placid, and dependent on others, or to be impulsive or easily frustrated. When we evaluate your adaptive functioning, we also consider the factors in 112.00F.

c. We consider your IQ score to be “valid” when it is supported by the other evidence, including objective clinical findings, other clinical observations, and evidence of your day-to-day functioning that is consistent with the test score. If the IQ test provides more than one IQ score (for example, a verbal, performance, and full scale IQ in a Wechsler series test), we use the lowest score. When we consider your IQ score, we apply the rules in 112.00D4.

d. In 112.05C, the term “severe” has the same meaning as in § 416.924(c). Your additional impairment(s) must cause more than slight or minimal physical or mental functional limitations. The limitations must

be separate from the limitations caused by your ID/MR.

e. Listing 112.05 is for ID/MR only. We evaluate other mental disorders that primarily affect cognition in the listing categories for dementia and amnesic and other cognitive disorders (112.02); autism spectrum disorders (112.10), or other disorders usually first diagnosed in childhood or adolescence (112.11), as appropriate.

#### 5. Anxiety Disorders (112.06)

a. These disorders are characterized by excessive anxiety, worry, apprehension, and fear, or by avoidance of feelings, thoughts, activities, objects, places, or persons.

b. Symptoms and signs may include, but are not limited to, restlessness, difficulty concentrating, hyper-vigilance, muscle tension, sleep disturbance, fatigue, panic attacks, obsessions and compulsions, constant thoughts and fears about safety, and frequent somatic complaints. Symptoms and signs associated with trauma may include recurrent intrusive recollections of a traumatic event, and acting or feeling as if the traumatic event were recurring. Depending on a child's age and developmental stage, other features may also include refusal to go to school, academic failure, frequent stomachaches and other physical complaints, extreme worries about sleeping away from home, being overly clinging, and exhibiting tantrums at times of separation from caregivers.

c. Examples of disorders in this category include panic disorder, phobic disorder, obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), generalized anxiety disorder, and anxiety disorder due to a general medical condition.

#### 6. Somatoform Disorders (112.07)

a. These disorders are characterized by physical symptoms or deficits that are not intentionally produced or feigned, and that, following clinical investigation, cannot be fully explained by a general medical condition, another mental disorder, the direct effects of a substance, or a culturally sanctioned behavior or experience.

b. Symptoms and signs may include, but are not limited to, pain and other abnormalities of sensation, gastrointestinal symptoms, fatigue, abnormal motor movement, pseudoseizures, and pseudoneurological symptoms, such as blindness or deafness.

c. Examples of disorders in this category include somatization disorder, conversion disorder, body dysmorphic disorder, and pain disorder associated with psychological factors.

#### 7. Personality Disorders (112.08)

a. These disorders are characterized by an enduring, inflexible, pervasive, and maladaptive pattern of inner experience and behavior that causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, and that has an onset in adolescence.

b. Symptoms and signs may include, but are not limited to, patterns of distrust, suspiciousness, and odd beliefs; social

detachment, discomfort, or avoidance; hypersensitivity to negative evaluation; an excessive need to be taken care of; difficulty making independent decisions; a preoccupation with orderliness, perfectionism, and control; grandiosity; inappropriate and intense anger; self-mutilating behaviors; and recurrent suicidal threats, gestures, or attempts.

c. Examples of disorders in this category include paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, dependent personality disorder, borderline personality disorder, and obsessive-compulsive personality disorder.

#### 8. Autism Spectrum Disorders (112.10)

a. These disorders are characterized by qualitative deficits in the development of reciprocal social interaction, verbal and nonverbal communication skills, and symbolic or imaginative play; restricted repetitive and stereotyped patterns of behavior, interests, and activities; and early stagnation of skill acquisition or loss of previously acquired skills.

b. Symptoms and signs may include, but are not limited to, abnormalities and unevenness in the development of cognitive skills; unusual responses to sensory stimuli; and behavioral difficulties, including hyperactivity, short attention span, impulsivity, aggressiveness, or self-injurious actions.

c. Examples of disorders in this category include autistic disorder, Asperger's disorder, and pervasive developmental disorder (PDD).

d. This category does not include mental disorders that are included in the listing categories for dementia and amnesic and other cognitive disorders (112.02), ID/MR (112.05), and other disorders usually first diagnosed in childhood or adolescence (112.11).

#### 9. Other Disorders Usually First Diagnosed in Childhood or Adolescence (112.11)

a. These disorders are characterized by onset during childhood or adolescence.

b. Symptoms and signs may include, but are not limited to, underlying abnormalities in cognitive processing (for example, deficits in learning and applying verbal or nonverbal information, visual perception, memory, or a combination of these), deficits in attention or impulse control, low frustration tolerance, excessive or poorly planned motor activity, difficulty with organizing (time, space, materials, or tasks), repeated accidental injury, and deficits in social skills. Symptoms and signs specific to some disorders in this category include fecal incontinence or urinary incontinence. Symptoms and signs specific to tic disorders include sudden, rapid, recurrent, non-rhythmic, stereotyped motor movement or vocalization; mood lability; and obsessions and compulsions.

c. Examples of disorders in this category include learning disorders; attention-deficit/hyperactivity disorder; elimination disorders, such as developmentally inappropriate encopresis and enuresis; and tic disorders, such as Tourette syndrome, chronic motor or vocal tic disorder, and transient tic disorder.

d. This category does not include mental disorders that are included in the listing

categories for dementia and amnesic and other cognitive disorders (112.02), ID/MR (112.05), and autism spectrum disorders (112.10).

#### 10. Eating Disorders (112.13)

a. These disorders are characterized by persistent eating of nonnutritive substances or repeated episodes of regurgitation and re-chewing of food, or by persistent failure to consume adequate nutrition by mouth. In adolescence, these disorders are characterized by disturbances in eating behavior and preoccupation with, and excessive self-evaluation of, body weight and shape.

b. Symptoms and signs may include, but are not limited to, failure to make expected weight gains; refusal to maintain a minimally normal weight or a minimally normal body mass index (BMI); recurrent episodes of binge eating and behavior intended to prevent weight gain, such as self-induced vomiting, excessive exercise, or misuse of laxatives; mood disturbances, social withdrawal, or irritability; amenorrhea; dental problems; abnormal laboratory findings; and cardiac abnormalities.

c. Examples of disorders in this category include pica, rumination disorder, and feeding disorders of early childhood; anorexia nervosa; and bulimia nervosa.

C. *What are the paragraph B criteria for children age 3 to the attainment of age 18?* The paragraph B criteria are the mental abilities a child uses to do age-appropriate activities. They are the abilities to: Understand, remember, and apply information (paragraph B1); interact with others (paragraph B2); concentrate, persist, and maintain pace (paragraph B3); and manage oneself (paragraph B4). In this section, we provide basic definitions of the four paragraph B mental abilities and some examples of how a child may use these mental abilities to function. In 112.00D, we explain how we rate the severity of limitations in the paragraph B mental abilities under these listings.

1. *Understand, remember, and apply information (paragraph B1).* This is the ability to acquire, retain, integrate, access, and use information to perform age-appropriate activities. You use this mental ability when, for example, you follow instructions, provide explanations, and identify and solve problems.

2. *Interact with others (paragraph B2).* This is the ability to relate to others at home, at school, and in the community. You use this mental ability when, for example, you initiate and maintain friendships, cooperate, handle conflicts, and respond to requests, suggestions, and criticism.

3. *Concentrate, persist, and maintain pace (paragraph B3).* This is the ability to focus attention on age-appropriate activities and to stay on task at a sustained rate. You use this mental ability when, for example, you concentrate, avoid distractions, initiate and complete activities, perform tasks at an appropriate and consistent speed, and sustain an ordinary routine.

4. *Manage oneself (paragraph B4).* This is the ability to regulate your emotions, control your behavior, and maintain your well-being in age-appropriate activities and settings.

You use this mental ability when, for example, you cope with your frustration and stress, respond to demands and changes in your environment, protect yourself from harm and exploitation by others, inhibit inappropriate actions, take your medications, and maintain your physical health, hygiene, and grooming.

D. *How do we use the paragraph B mental abilities to evaluate mental disorders in children from age 3 to the attainment of age 18?*

##### 1. General

a. When we rate your limitations using the paragraph B mental abilities, we consider only limitations you have because of your mental disorder.

b. We evaluate your limitations in the context of what is typically expected of children your age without mental disorders. To do most age-appropriate activities, a child is expected to use his or her mental abilities (given age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis.

c. Marked or extreme limitation of a paragraph B mental ability reflects the overall degree to which your mental disorder interferes with your using that ability (given age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis to do age-appropriate activities. It does not necessarily reflect a specific type or number of activities, including activities of daily living, that you have difficulty doing. In addition, no single piece of information (including test scores) can establish whether you have marked or extreme limitation of a paragraph B mental ability. (See 112.00D4.)

d. Marked or extreme limitation of a paragraph B mental ability also reflects the kind and extent of supports you receive (beyond the supports that other children your age without mental disorders typically receive) and the characteristics of any highly structured setting in which you spend your time that enable you to function as you do. The more extensive the supports or the more structured the setting you need to function, the more limited we will find you to be. (See 112.00F and § 416.924a.)

##### 2. What we mean by "marked" limitation

a. *Marked limitation* of a paragraph B mental ability means that the symptoms and signs of your mental disorder interfere *seriously* with your using that mental ability (given age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis to do age-appropriate activities. Although we do not require the use of such a scale, marked would be the fourth point on a five-point rating scale consisting of no limitation, slight limitation, moderate limitation, marked limitation, and extreme limitation.

b. Although we do not require standardized test scores to determine whether you have marked limitations, we will generally find that you have marked limitation of a paragraph B mental ability when you have a valid score that is at least two, but less than three, standard deviations below the mean on an individually administered standardized test designed to measure that ability and the evidence shows that your functioning over time is consistent with the score. (See also 112.00D4.)

c. Marked limitation is also the equivalent of the level of limitation we would expect to find on standardized testing with scores that are at least two, but less than three, standard deviations below the mean for your age.

3. *What we mean by "extreme" limitation*

a. *Extreme limitation* of a paragraph B mental ability means that the symptoms and signs of your mental disorder interfere *very seriously* with your using that mental ability (given age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis to do age-appropriate activities. Although we do not require the use of such a scale, extreme would be the last point on a five-point rating scale consisting of no limitation, slight limitation, moderate limitation, marked limitation, and extreme limitation.

b. Although we do not require standardized test scores to determine whether you have extreme limitation, we will generally find that you have extreme limitation of a paragraph B mental ability when you have a valid score that is at least three standard deviations below the mean for your age on an individually administered standardized test designed to measure that ability and the evidence shows that your functioning over time is consistent with the score. (See also 112.00D4.)

c. "Extreme" is the rating we give to the worst limitations; however, it does not necessarily mean a total lack or loss of ability to function. It is the equivalent of the level of limitation we would expect to find on standardized testing with scores that are at least three standard deviations below the mean for your age.

4. *How we consider your test results*

a. We do not rely on any IQ score or other test result alone. We consider your test scores together with the other information we have about how you use the mental abilities described in the paragraph B criteria in your day-to-day functioning.

b. We may find that you have "marked" or "extreme" limitation when you have a test score that is slightly higher than the levels we provide in 112.00D2 and D3 if other information in your case record shows that your functioning in day-to-day activities is seriously or very seriously limited. We will not find that you have "marked" or "extreme" limitation in your ability to understand, remember, and apply information (or in any other ability measured by a standardized test) unless you have evidence demonstrating that your functioning is consistent with such a limitation.

c. Generally, we will not find that a test result is valid for our purposes when the information we have about your functioning is of the kind typically used by medical professionals to determine that the test results are not the best measure of your day-to-day functioning. If there is a material inconsistency between your test results and other information in your case record, we will try to resolve it. We use the following guidelines when we consider your test scores:

(i) The interpretation of the test is primarily the responsibility of the professional who administered the test. The narrative report that accompanies the test

results should specify whether the results are deemed to be valid; that is, whether they are consistent with your medical and developmental history and information about your day-to-day functioning.

(ii) It is our responsibility to ensure that the evidence in your case record is complete and to resolve any material inconsistencies in the evidence. In some cases, we will be able to resolve an inconsistency with the information already in your case record. In others, we may need to request additional information; for example, by recontacting your medical source(s), by purchasing a consultative examination, or by questioning persons who are familiar with your day-to-day functioning.

E. *What are the paragraph C criteria, and how do we use them to evaluate mental disorders in children age 3 to the attainment of age 18?*

1. *General.* We use the paragraph C criteria as an alternative to paragraph B to evaluate "serious and persistent mental disorders" under every mental disorders listing except 112.05. We can use the paragraph C criteria without first considering whether your mental disorder satisfies the paragraph B criteria.

2. *Paragraph C criteria*

a. To meet the paragraph C criteria, you must have a medically documented history, over a period of at least 1 year, of the existence of a serious and persistent mental disorder. Your mental disorder must also satisfy the criteria in C1 and C2.

b. *The criterion in C1* is satisfied when the evidence shows that continuing treatment, psychosocial support(s), or a highly structured setting(s) diminishes the symptoms and signs of your mental disorder. (See 112.00F.)

c. *The criterion in C2* is satisfied when the evidence shows that you have achieved only marginal adjustment despite your diminished symptoms and signs. "Marginal adjustment" means that your adaptation to the requirements of daily living and your environment is fragile; that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life. Changes or increased demands would likely lead to an exacerbation of your symptoms and signs and to deterioration in your functioning; for example, you would be unable to function outside a highly structured setting or outside your home. Similarly, because of the nature of your mental disorder, you could experience episodes of deterioration that require you to be hospitalized or absent from school, making it difficult for you to sustain age-appropriate activity over time.

F. *How do we consider psychosocial supports, highly structured settings, and treatment when we evaluate the functioning of children age 3 to the attainment of age 18?*

1. *Psychosocial supports and highly structured settings* may help you to function by reducing the demands made on you. However, your ability to function in settings (including your own home) that are less demanding, more structured, or more supportive than those in which children typically function does not necessarily show how you would function in school or other

age-appropriate settings on a sustained basis. Therefore, we will consider the kind and extent of supports you receive and the characteristics of any structured setting in which you spend your time (compared to children your age without mental disorders) when we evaluate the effect of your mental disorder on your functioning and rate the limitation of your mental abilities (see 112.00D).

2. *Examples of psychosocial supports and highly structured settings*

a. You need family members or other persons to help you in ways that children your age without mental disorders typically do not need to function age-appropriately; for example, you need an aide to accompany you on the school bus to help you control your actions or to monitor you to be sure you are not being self-injurious or injurious to others.

b. You receive one-on-one assistance in your classes every day, or you have a personal aide who helps you daily to function in your classroom.

c. You are a student in a self-contained classroom or attend a separate or alternative school where you receive special education services (see 112.00G4).

d. You are a student in a special education setting that teaches you daily living skills, vocational skills, or entry-level work to help you be independent when you become an adult (see 112.00G4).

e. You participate in a sheltered, supported, or transitional work program or in a competitive employment setting with the help of a job coach or an accommodating supervisor (see 112.00G4).

f. You receive treatment in a day program at a hospital, community treatment program, or other daily outpatient program.

g. You live in a group home, halfway house, or semi-independent living program with a counselor or resident supervisor who is there 24 hours a day.

h. You live in a residential school, hospital, or other institution with 24-hour care.

3. *Treatment*

a. With treatment, such as medications and social skills training, you may not only have your symptoms and signs reduced, but may be able to function well enough to perform age-appropriate activities.

b. Treatment may not resolve all of the functional limitations that result from your mental disorder, and the medications you take or other treatment you receive for your disorder may cause side effects that affect your mental or physical functioning; for example, you may experience drowsiness, blunted affect, or abnormal involuntary movements.

c. We will consider the effect of any treatment on your functioning when we evaluate your mental disorder under these listings.

G. *What evidence do we need to evaluate your developmental or mental disorder?*

1. *General*

a. If you have not attained age 3, we need evidence to assess the existence and severity of your developmental disorder and its effects on your ability to acquire and maintain the skills needed to function age-appropriately. (See 112.00I for guidelines

about evaluating developmental disorders in infants and toddlers under 112.14.)

b. If you are age 3 to the attainment of age 18, we need evidence to assess the existence and severity of your mental disorder and its effects on your ability to function age-appropriately.

c. Although we always need evidence from an acceptable medical source, the individual facts of your case will determine the extent of that evidence and what evidence, if any, we need from other sources. For our basic rules on evidence, *see* §§ 416.912 and 416.913. For our rules on evidence about a child's symptoms, *see* § 416.929.

2. *Evidence from medical sources.* We will consider all relevant medical evidence about your mental disorder from your physician, psychologist, and your other medical sources. Other medical sources include health care providers, such as physician assistants, nurses, licensed clinical social workers, and therapists. These other medical sources can be very helpful in providing evidence to assess the severity of your mental disorder and the resulting limitation in functioning, especially if they see you regularly. Evidence from medical sources may include:

- a. Your reported symptoms.
  - b. Your medical, developmental, psychiatric, and psychological history.
  - c. The results of physical or mental status examinations or other clinical findings.
  - d. Psychological testing, developmental assessments, imaging studies, or other laboratory findings.
  - e. Your diagnosis.
  - f. The type, dosage, frequency, duration, and beneficial effects of medications you receive.
  - g. The type, frequency, duration, and beneficial effects of therapy, counseling, or early intervention you receive.
  - h. Any side effects of medication or other treatment that limit your ability to function (*see* 112.00F).
  - i. Your clinical course, including changes in your medication, therapy, or counseling and the time required for therapeutic effectiveness.
  - j. Observations and descriptions of how you function.
  - k. Any psychosocial support(s) you receive or highly structured setting(s) in which you are involved (*see* 112.00F).
  - l. Any sensory, motor, or speaking abnormalities or information about your cultural background (for example, language differences, customs) that may affect an evaluation of your developmental or mental disorder.
  - m. The expected duration of your symptoms and signs and their effects on your ability to function age-appropriately over time.
3. *Evidence from you and persons who know you.* We will ask you to describe your symptoms and your limitations if you are able to do so, and we will use that information to help us determine whether you are disabled. We will also consider information from persons who can describe how you usually function from day to day when we need it to show the severity of your mental disorder and how it affects your

ability to function. This information may include, but is not limited to, information from your family, other caregivers, friends, neighbors, or clergy. We will consider your statements and the statements of other persons to determine if they are consistent with the medical and other evidence we have.

4. *Evidence from early intervention programs, school, vocational training, work, and work-related programs.*

a. If you receive services in an Early Intervention Program to help you with your special developmental needs, we will consider information from your Individualized Family Service Plan (IFSP) when we need it to show the severity of your developmental disorder.

b. If you receive special education or related services at your preschool or school, we will consider the information in your Individualized Education Program (IEP) when we need it to show the severity of your mental disorder and how it affects your ability to function. The information may come from classroom teachers, special educators, nurses, school psychologists, and occupational, physical, and speech/language therapists. It may include, but is not limited to, comprehensive evaluation reports, IEPs, education records, therapy progress notes, information from your teachers about how you function in their classrooms, and information about any special education services or accommodations you receive at school.

c. If you have recently attended or are still attending vocational training classes or if you have attempted to work or are working now, we will consider information from your training program or your employer when we need it to show the severity of your mental disorder and how it affects your ability to function. This information may include, but is not limited to, training or work evaluations, modifications to your work duties or work schedule, and any special supports or accommodations you have required or now require in order to work. If you have worked or are working through a community mental health program, a sheltered work program, a supported work program, a rehabilitation program, or a transitional employment program, we will consider the type and degree of support you have received or are receiving in order to work.

5. *Evidence from developmental assessments or psychological and psychiatric measures.* We will consider the results from developmental assessments or from psychological and psychiatric measures together with all the other evidence in your case record. Results from these measures are only part of the evidence we use in our overall disability evaluation; we will not use these results alone to decide whether you are disabled. (*See* 112.00D4.)

6. *Need for longitudinal evidence.*

a. Many children with mental disorders experience periods of worsening of the symptoms and signs of their mental disorders (exacerbations) and periods of improvement of their symptoms and signs (remissions). Exacerbations may make it difficult for you to function age-appropriately on a sustained

basis. Therefore, we generally will consider how you function longitudinally; that is, over time. We will not find that you are able to function age-appropriately solely because you have a period(s) of remission, or that you are disabled solely because you have an exacerbation(s) of your mental disorder. We will consider how often you have remissions and exacerbations and how long they last, what causes your mental disorder to improve or worsen, and any other information that is relevant to our determination about how you function over time. We will consider longitudinal evidence from relevant sources over a sufficient period to establish the severity of your mental disorder over time.

b. If you have a serious mental disorder, you will probably have evidence of its effects on your functioning over time, even if you do not have an ongoing relationship with the medical community. For example, family members, friends, day-care providers, teachers, neighbors, former employers, social workers, mental health clinics, emergency shelters, law enforcement, or government agencies may be familiar with your mental health history.

c. You may function differently and appear more or less limited in an unfamiliar or one-time situation, such as a consultative examination, than is indicated by other information about your functioning over time (*see* § 416.924a(b)(6)). Your ability to function during a time-limited mental status examination or psychological testing, or in another unfamiliar or one-time situation, does not necessarily show how you will be able to function in a school or other age-appropriate setting on a sustained basis.

d. Some of your day-to-day activities, or some of the places where you spend time each day, can be stressful if you have a mental disorder, making it difficult for you to function as other children without mental disorders typically do. For example, you may have to leave your home to go to daycare where the level of activity and noise is stressful to you; or you may feel stressed when you move from elementary to middle school, where you have to change classrooms and settle yourself down to new situations and settings many times during each day.

(i) Your reaction to stress associated with the demands of your day-to-day activities may be different from another child's; that is, the symptoms and signs of your mental disorder may be more or less affected by stress than those of another child with the same mental disorder or another mental disorder.

(ii) We will consider evidence from all sources about the effects of stress on your mental abilities. We will also take into consideration what, if any, psychosocial support(s) or structure you would need when you experience stress (*see* 112.00F).

H. *How do we evaluate substance use disorders?* If we find that you are disabled and there is medical evidence in your case record establishing that you have a substance use disorder, we will determine whether your substance use disorder is a contributing factor material to the determination of disability. (*See* § 416.935.)

I. *How do we use 112.14 to evaluate developmental disorders of infants and toddlers from birth to attainment of age 3?*

1. *General.* If you are a child from birth to attainment of age 3 with a developmental disorder, we use 112.14 to evaluate your ability to acquire and maintain the motor, cognitive, social/communicative, and emotional skills you need to function age-appropriately. When we rate your impairment-related limitations for this listing, we consider only limitations you have because of your developmental disorder. If you have a somatic illness or physical abnormalities, we will evaluate them under the affected body system; for example, the musculoskeletal or neurological system.

2. *Description of 112.14*

a. Developmental disorders are characterized by a delay or deficit in the development of age-appropriate skills or a loss of previously acquired skills involving motor planning and control, learning, relating socially and communicating, and self-regulating.

b. Examples of disorders in this category include feeding and eating disorders, sensory processing disorder, developmental coordination disorder, autism and other pervasive developmental disorders, separation anxiety disorder, and regulatory disorders. Some infants and toddlers may have a diagnosis of “developmental delay.”

c. When we evaluate your developmental disorder, we will consider the wide variation in the range of normal or typical development in early childhood. Your emerging skills at the end of an expected milestone period may or may not indicate developmental delay or a delay that can be expected to last for 12 months.

3. *What are the paragraph B criteria for 112.14?*

a. *General.* The paragraph B criteria are the developmental abilities that infants and toddlers use to acquire and maintain the skills needed to function age-appropriately. They are the abilities to: Plan and control motor movement (paragraph B1); learn and remember (paragraph B2); interact with others (paragraph B3); and regulate physiological functions, attention, emotion, and behavior (paragraph B4). We use these criteria to evaluate limitations that result from the developmental disorder. In 112.0013b(i) through 13b(iv), we provide some examples of how infants and toddlers use these developmental abilities to function age-appropriately. In 112.0014, we explain how we rate the severity of limitations in the paragraph B mental abilities under 112.14.

b. *Definitions of the paragraph B developmental abilities*

(i) *Ability to plan and control motor movement (paragraph B1).* This is the ability to plan, remember, and execute controlled motor movements by integrating and coordinating perceptual and sensory input with motor output. Using this ability develops gross and fine motor skills, and makes it possible for you to engage in age-appropriate symmetrical or alternating motor activities. You use this ability when, for example, you walk, pull yourself up to stand, grasp and hold objects with one or both hands, and go up and down stairs with alternating feet.

(ii) *Ability to learn and remember (paragraph B2).* This is the ability to learn by

exploring the environment, engaging in trial-and-error experimentation, putting things in groups, understanding that words represent things, and participating in pretend play. Using this ability develops the skills that help you understand what things mean, how things work, and how you can make things happen. You use this ability when, for example, you show interest in objects that are new to you, imitate simple actions, name body parts, understand simple cause-and-effect relationships, remember simple directions, or figure out how to take something apart.

(iii) *Ability to interact with others (paragraph B3).* This is the ability to participate in reciprocal social interactions and relationships by communicating your feelings and intents through vocal and visual signals and exchanges; physical gestures, contact, and proximity; shared attention and affection; verbal turn-taking; and increasingly complex messages. Using this ability develops the social skills that make it possible for you to influence others (for example, by gesturing for a toy or saying “no” to stop an action); invite someone to interact with you (for example, by smiling or reaching); and draw someone’s attention to what interests you (for example, by pointing or taking your caregiver’s hand and leading that person). You use this ability when, for example, you use vocalizations to initiate and sustain a “conversation” with your caregiver; respond to limits set by an adult with words, gestures, or facial expressions; play alongside another child; or participate in simple group activities with adult help.

(iv) *Ability to regulate physiological functions, attention, emotion, and behavior (paragraph B4).* This is the ability to stabilize biological rhythms (for example, by acquiring a sleep/wake cycle); control physiological functions (for example, by achieving regular patterns of feeding); and attend, react, and adapt to environmental stimuli, persons, objects, and events (for example, by becoming alert to things happening around you and in relation to you, and responding without overreacting or underreacting). Using this ability develops the skills you need to regulate yourself and makes it possible for you to achieve and maintain a calm, alert, and organized physical and emotional state. You use this ability when, for example, you recognize your body’s needs for food or sleep, focus quickly and pay attention to things that interest you, cry when you are hurt but quiet when your caregiver holds you, comfort yourself with your favorite toy when you are upset, ask for help when something frustrates you, or refuse help from your caregiver when trying to do something for yourself.

4. *How do we use the 112.14 criteria to evaluate your developmental disorder?*

a. We will find that your developmental disorder meets the requirements of 112.14 if it results in marked limitations of two or extreme limitation of one of the paragraph B developmental abilities.

b. We will evaluate your limitations in the context of what is typically expected of infants or toddlers your age without developmental disorders. An infant or toddler is expected to use his or her

developmental abilities to achieve a recognized pattern of milestones, over a typical range of time, in order to acquire and maintain the skills needed to function age-appropriately.

c. Marked or extreme limitation of a paragraph B developmental ability reflects the overall degree to which your developmental disorder interferes with your using that ability. It does not necessarily reflect a specific type or number of developmental skills or activities that you have difficulty doing. In addition, no single piece of information, including test scores, can establish whether you have marked or extreme limitation of a paragraph B developmental ability. (See 112.00H4g.)

d. Marked or extreme limitation of a paragraph B developmental ability also reflects the kind and extent of supports you receive (beyond the supports that infants or toddlers your age without developmental disorders typically receive), and the characteristics of any highly structured settings in which you spend your time, that enable you to function as you do. The more extensive the supports or the more structured the setting you need to function, the more limited we will find you to be. (See 112.0015 and § 416.924a.)

e. *What we mean by “marked” limitation*

(i) *Marked limitation* of a paragraph B developmental ability means that the symptoms and signs of your developmental disorder interfere *seriously* with your using that ability to acquire and maintain the skills you need to function age-appropriately. Although we do not require the use of such a scale, marked would be the fourth point on a five-point rating scale consisting of no limitation, slight limitation, moderate limitation, marked limitation, and extreme limitation.

(ii) Although we do not require standardized test scores to determine whether you have marked limitations, we will generally find that you have marked limitation of a paragraph B developmental ability when you have a valid score that is at least two, but less than three, standard deviations below the mean on a comprehensive standardized developmental assessment designed to measure that ability and the evidence shows that your functioning over time is consistent with the score.

(iii) Marked limitation is also the equivalent of the level of limitation we would expect to find on standardized developmental assessments with scores that are at least two, but less than three, standard deviations below the mean for your age.

(iv) When there are no results from a comprehensive standardized developmental assessment in your case record, we can evaluate your disorder based on a comprehensive clinical developmental assessment; that is, an assessment of more than one or two isolated skills, with abnormal findings noted on repeated examinations. We will find marked limitation of a paragraph B developmental ability if your skills and functioning on a clinical developmental assessment are at a level that is typical of children who are more than one-half, but not more than two-thirds, your chronological age.

f. *What we mean by “extreme” limitation*

(i) *Extreme limitation* of a paragraph B developmental ability means that the symptoms and signs of your developmental disorder interfere *very seriously* with your ability to acquire and maintain the skills that you need to function age-appropriately. Although we do not require the use of such a scale, extreme would be the last point on a five-point rating scale consisting of no limitation, slight limitation, moderate limitation, marked limitation, and extreme limitation.

(ii) Although we do not require standardized test scores to determine whether you have extreme limitation, we will generally find that you have extreme limitation of a paragraph B developmental ability when you have a valid score that is at least three standard deviations below the mean on a comprehensive standardized developmental assessment designed to measure that ability and the evidence shows that your functioning over time is consistent with the score.

(iii) “Extreme” is the rating we give to the worst limitations; however, it does not necessarily mean a total lack or loss of ability to function. It is the equivalent of the level of limitation we would expect to find on standardized developmental assessments with scores that are at least three standard deviations below the mean for your age.

(iv) When there are no results from a comprehensive standardized developmental assessment in your case record, we can evaluate your disorder based on a comprehensive clinical developmental assessment; that is, an assessment of more than one or two isolated skills, with abnormal findings noted on repeated examinations. We will find extreme limitation of a paragraph B developmental ability if your skills and functioning on a clinical developmental assessment are at a level that is typical of children who are no more than one-half your chronological age.

g. *How we consider your test results.* We use the rules in 112.00D4 to evaluate any test results in your case record.

5. *How do we consider supports when we evaluate functioning under 112.14?*

a. If you have a developmental delay or your skills are qualitatively deficient, you may receive support in the form of early intervention services to help you acquire needed skills or to improve those that you have.

b. You may receive therapeutic intervention, such as occupational therapy, from a visiting early childhood specialist or therapist who sees you in your home or in a structured clinical setting that is specially designed to enable you to develop specific skills. You may receive more direct help at home in acquiring skills than other children your age when, for example, your caregiver repeatedly models a sequence of physical actions for you to imitate or spends large amounts of time helping you to calm yourself when you are upset. Generally, the more direct help or therapeutic intervention you need to develop skills compared to other infants and toddlers your age without developmental disorders, the more limited we will find you to be.

6. *Deferral of determination*

a. *Full-term infants*

(i) In the first few months of life, full-term infants typically display some irregularities in observable behaviors (for example, sleep cycles, feeding, responding to stimuli, attending to faces, self-calming), making it difficult to assess the presence, severity, and duration of a developmental disorder.

(ii) When the evidence indicates that you may have a significant developmental delay, but there is insufficient evidence to make a determination, we will defer making a disability determination under 112.14 until you are at least 6 months old. This will allow us to obtain a longitudinal medical history so that we can more accurately evaluate your developmental patterns and functioning over time. When you are at least 6 months old, any developmental delay you may have can be better assessed, and you can undergo standardized developmental testing, if indicated.

b. *Premature infants.* If you were born prematurely, we will follow the rules in § 416.924b(b) to determine your *corrected chronological age*; that is, the chronological age adjusted by the period of gestational prematurity. When the evidence indicates that you may have a significant developmental delay, but there is insufficient evidence to make a determination, we will defer your case until you attain a corrected chronological age of at least 6 months in order to better evaluate your developmental delay.

c. *When we will not defer a determination.* We will not defer our determination if we have sufficient evidence to determine that you are disabled under 112.14 or any other listing, or that you have a combination of impairments that functionally equals the listings. In addition, we will not defer our determination if the evidence demonstrates that you are not disabled.

J. How do we evaluate mental and developmental disorders that do not meet one of the mental disorders listings?

1. These listings include only examples of mental and developmental disorders that we consider severe enough to result in marked and severe functional limitations. If your severe mental or developmental disorder does not meet the criteria of any of these listings, we will also consider whether you have an impairment(s) that meets the criteria of a listing in another body system. You may have a separate other impairment(s) or a physical impairment(s) that is secondary to your mental disorder. For example, if you have an eating disorder and develop a cardiovascular impairment because of it, we will evaluate your cardiovascular impairment under the listings for the cardiovascular body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. (See § 416.926.) If it does not, we will also consider whether you have an impairment(s) that functionally equals the listings. (See § 416.926a.) When we determine whether your impairment(s) functionally equals the listings, we consider all of your physical and mental limitations.

If you have limitations in your ability to perform physical activities that are secondary to your mental or developmental disorder, we will consider them when we determine whether your disorder functionally equals the listings. For example, limitations in walking or standing due to the side effects of medication you take to treat your mental disorder may affect your age-appropriate activities requiring physical exertion. When we decide whether you continue to be disabled, we use the rules in §§ 416.994 and 416.994a.

**112.01 Category of Impairments, Mental Disorders**

112.02 *Dementia and Amnesic and Other Cognitive Disorders*, with both A and B or both A and C.

A. For children age 3 to attainment of age 18, a medically determinable mental disorder in this category (see 112.00B1).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (see 112.00C1).
2. Ability to interact with others (see 112.00C2).
3. Ability to concentrate, persist, and maintain pace (see 112.00C3).
4. Ability to manage oneself (see 112.00C4).

OR

C. A serious and persistent mental disorder in this category (see 112.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 112.00E2c.

112.03 *Schizophrenia and Other Psychotic Disorders*, with both A and B or both A and C.

A. For children age 3 to attainment of age 18, a medically determinable mental disorder in this category (see 112.00B2).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (see 112.00C1).
2. Ability to interact with others (see 112.00C2).
3. Ability to concentrate, persist, and maintain pace (see 112.00C3).
4. Ability to manage oneself (see 112.00C4).

OR

C. A serious and persistent mental disorder in this category (see 112.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 112.00E2c.

112.04 *Mood Disorders*, with both A and B or both A and C.

A. For children age 3 to attainment of age 18, a medically determinable mental disorder in this category (see 112.00B3).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (*see* 112.00C1).
2. Ability to interact with others (*see* 112.00C2).
3. Ability to concentrate, persist, and maintain pace (*see* 112.00C3).
4. Ability to manage oneself (*see* 112.00C4).

OR

C. A serious and persistent mental disorder in this category (*see* 112.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 112.00E2c.

112.05 *Intellectual Disability/Mental Retardation* (ID/MR) satisfying A, B, C, or D.

A. For children age 3 to the attainment of age 18, ID/MR as defined in 112.00B4, with mental incapacity evidenced by dependence upon others for personal needs (grossly in excess of age-appropriate dependence) and an inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded.

OR

B. For children age 3 to the attainment of age 18, ID/MR as defined in 112.00B4, with a valid IQ score of 59 or less (as defined in 112.00B4d) on an individually administered standardized test of general intelligence having a mean of 100 and a standard deviation of 15 (*see* 112.00D4).

OR

C. For children age 3 to the attainment of age 18, ID/MR as defined in 112.00B4, with a valid IQ score of 60 through 70 (as defined in 112.00B4d) on an individually administered standardized test of general intelligence having a mean of 100 and a standard deviation of 15 (*see* 112.00D4) and with another "severe" physical or mental impairment (*see* 112.00B4e).

OR

D. For children from age 3 to the attainment of age 18, ID/MR as defined in 112.00B4, with a valid IQ score of 60 through 70 (as defined in 112.00B4d) on an individually administered standardized test of general intelligence having a mean of 100 and a standard deviation of 15 (*see* 112.00D4), resulting in *marked* limitation of at least two of the following mental abilities:

1. Ability to understand, remember, and apply information (*see* 112.00C1).
2. Ability to interact with others (*see* 112.00C2).
3. Ability to concentrate, persist, and maintain pace (*see* 112.00C3).
4. Ability to manage oneself (*see* 112.00C4).

112.06 *Anxiety Disorders*, with both A and B or both A and C.

A. For children age 3 to attainment of age 18, a medically determinable mental disorder in this category (*see* 112.00B5).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (*see* 112.00C1).
2. Ability to interact with others (*see* 112.00C1).
3. Ability to concentrate, persist, and maintain pace (*see* 112.00C3).
4. Ability to manage oneself (*see* 112.00C4).

OR

C. A serious and persistent mental disorder in this category (*see* 112.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 112.00E2c.

112.07 *Somatoform Disorders*, with both A and B or both A and C.

A. For children age 3 to attainment of age 18, a medically determinable mental disorder in this category (*see* 112.00B6).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (*see* 112.00C1).
2. Ability to interact with others (*see* 112.00C2).
3. Ability to concentrate, persist, and maintain pace (*see* 112.00C3).
4. Ability to manage oneself (*see* 112.00C4).

OR

C. A serious and persistent mental disorder in this category (*see* 112.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 112.00E2c.

112.08 *Personality Disorders*, with both A and B or both A and C.

A. For children age 3 to attainment of age 18, a medically determinable mental disorder in this category (*see* 112.00B7).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (*see* 112.00C1).
2. Ability to interact with others (*see* 112.00C2).
3. Ability to concentrate, persist, and maintain pace (*see* 112.00C3).
4. Ability to manage oneself (*see* 112.00C4).

OR

C. A serious and persistent mental disorder in this category (*see* 112.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 112.00E2c.

112.10 *Autism Spectrum Disorders*, with both A and B or both A and C.

A. For children age 3 to attainment of age 18, a medically determinable mental disorder in this category (*see* 112.00B8).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (*see* 112.00C1).
2. Ability to interact with others (*see* 112.00C2).
3. Ability to concentrate, persist, and maintain pace (*see* 112.00C3).
4. Ability to manage oneself (*see* 112.00C4).

OR

C. A serious and persistent mental disorder in this category (*see* 112.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 112.00E2c.

112.11 *Other Disorders Usually First Diagnosed in Childhood or Adolescence*, with both A and B or both A and C.

A. For children age 3 to attainment of age 18, a medically determinable mental disorder in this category (*see* 112.00B9).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (*see* 112.00C1).
2. Ability to interact with others (*see* 112.00C2).
3. Ability to concentrate, persist, and maintain pace (*see* 112.00C3).
4. Ability to manage oneself (*see* 112.00C4).

OR

C. A serious and persistent mental disorder in this category (*see* 112.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*
2. Marginal adjustment, as described in 112.00E2c.

112.13 *Eating Disorders*, with both A and B or both A and C.

A. For children age 3 to attainment of age 18, a medically determinable mental disorder in this category (*see* 112.00B10).

AND

B. *Marked* limitations of *two* or *extreme* limitation of *one* of the following mental abilities:

1. Ability to understand, remember, and apply information (*see* 112.00C1).
2. Ability to interact with others (*see* 112.00C2).
3. Ability to concentrate, persist, and maintain pace (*see* 112.00C3).
4. Ability to manage oneself (*see* 112.00C4).

OR

C. A serious and persistent mental disorder in this category (*see* 112.00E2) with both:

1. Continuing treatment, psychosocial support(s), or a highly structured setting(s) that diminishes the symptoms and signs of your mental disorder, *and*



2. Marginal adjustment, as described in 112.00E2c.

112.14 *Developmental Disorders of Infants and Toddlers*, with both A and B.

A. For children from birth to attainment of age 3, a medically determinable developmental disorder in this category (see 112.00I2).

AND

B. *Marked* limitations of two or *extreme* limitation of one of the following developmental abilities:

1. Ability to plan and control motor movement (see 112.00I3b(i)).

2. Ability to learn and remember (see 112.00I3b(ii)).

3. Ability to interact with others (see 112.00I3b(iii)).

4. Ability to regulate physiological functions, attention, emotion, and behavior (see 112.00I3b(iv)).

\* \* \* \* \*

#### 114.00 Immune System Disorders

\* \* \* \* \*

D. *How do we document and evaluate the listed autoimmune disorders?*

\* \* \* \* \*

6. *Inflammatory arthritis (114.09)*.

\* \* \* \* \*

e. *How we evaluate inflammatory arthritis under the listings.*

\* \* \* \* \*

(ii) Listing-level severity is shown in 114.09B and 114.09C2 by inflammatory arthritis that involves various combinations of complications of one or more major peripheral joints or involves other joints, such as inflammation or deformity, extra-articular features, repeated manifestations, and constitutional symptoms and signs.

\* \* \* \* \*

#### 114.01 Category of Impairments, Immune System Disorders

114.02 *Systemic lupus erythematosus*, as described in 114.00D1. With involvement of two or more organs/body systems, and with:

A. One of the organs/body systems involved to at least a moderate level of severity;

AND

B. At least two of the constitutional symptoms and signs (severe fatigue, fever, malaise, or involuntary weight loss).

114.03 *Systemic vasculitis*, as described in 114.00D2. With involvement of two or more organs/body systems, and with:

A. One of the organs/body systems involved to at least a moderate level of severity;

AND

B. At least two of the constitutional symptoms and signs (severe fatigue, fever, malaise, or involuntary weight loss).

\* \* \* \* \*

114.06 *Undifferentiated and mixed connective tissue disease*, as described in 114.00D5. With involvement of two or more organs/body systems, and with:

A. One of the organs/body systems involved to at least a moderate level of severity;

AND

B. At least two of the constitutional symptoms and signs (severe fatigue, fever, malaise, or involuntary weight loss).

\* \* \* \* \*

114.10 *Sjögren's syndrome*, as described in 114.00D7. With involvement of two or more organs/body systems, and with:

A. One of the organs/body systems involved to at least a moderate level of severity;

AND

B. At least two of the constitutional symptoms and signs (severe fatigue, fever, malaise, or involuntary weight loss).

#### Subpart Q—[Amended]

7. The authority citation for subpart Q of part 404 continues to read as follows:

**Authority:** Secs. 205(a), 221, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 421, and 902(a)(5)).

8. Amend § 404.1615 by adding a new fifth sentence at the end of paragraph (d) to read as follows:

#### § 404.1615 Making disability determinations.

\* \* \* \* \*

(d) \* \* \* See § 404.1503 regarding overall responsibility for reviewing mental impairments in the State agency.

\* \* \* \* \*

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

##### Subpart I—[Amended]

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

**Authority:** Secs. 221(m), 702(a)(5), 1611, 1614, 1619, 1631(a), (c), (d)(1), and (p), and 1633 of the Social Security Act (42 U.S.C. 421(m), 902(a)(5), 1382, 1382c, 1382h, 1383(a), (c), (d)(1), and (p), and 1383b); secs. 4(c) and 5, 6(c)–(e), 14(a), and 15, Pub. L. 98–460, 98 Stat. 1794, 1801, 1802, and 1808 (42 U.S.C. 421 note, 423 note, and 1382h note).

10. Amend § 416.903 by redesignating paragraph (e) as paragraph (e)(1) and adding a new paragraph (e)(2), to read as follows:

#### § 416.903 Who makes disability and blindness determinations.

\* \* \* \* \*

(e) \* \* \*

(2) *Overall responsibility for evaluating mental impairments.* (i) In any case at the initial and reconsideration levels, except in cases in which a disability hearing officer makes the reconsideration determination, our medical or psychological consultant has overall responsibility for assessing the medical severity of your mental impairment(s). The State agency disability examiner

may assist in reviewing the claim and preparing documents that contain the medical portion of the case review and any applicable residual functional capacity assessment or determination about functional equivalence. However, our medical or psychological consultant must review and sign any document(s) that includes the medical portion of the case review and any applicable residual functional capacity assessment or determination about functional equivalence to attest that they are complete and that he or she is responsible for the content, including the findings of fact and any discussion of supporting evidence. When a disability hearing officer makes a reconsideration determination, the disability hearing officer has overall responsibility for assessing the medical severity of your mental impairment(s). The determination must document the disability hearing officer's pertinent findings and conclusions regarding the mental impairment(s).

(ii) At the administrative law judge hearing and Appeals Council levels, the administrative law judge or, if the Appeals Council makes a decision, the Appeals Council has overall responsibility for assessing the medical severity of your mental impairment(s). The written decision must incorporate the pertinent findings and conclusions of the administrative law judge or Appeals Council.

#### § 416.920a [Removed]

11. Remove § 416.920a.

12. Revise the heading of § 416.934 and paragraph (h) to read as follows:

#### § 416.934 Impairments that may warrant a finding of presumptive disability or presumptive blindness.

\* \* \* \* \*

(h) Allegation of intellectual disability/mental retardation or another cognitive impairment (for example, an autism spectrum disorder) with complete inability to independently perform basic self-care activities (such as toileting, eating, dressing, or bathing) made by another person who files on behalf of a claimant who is at least 4 years old.

\* \* \* \* \*

#### Subpart J—[Amended]

13. The authority citation for subpart J of part 416 continues to read as follows:

**Authority:** Secs. 702(a)(5), 1614, 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1382c, 1383, and 1383b).

14. Amend section 416.1015 by adding a new fifth sentence at the end of paragraph (d) to read as follows:

**§ 416.1015 Making disability determinations.**

\* \* \* \* \*

(d) \* \* \* See § 416.903 regarding overall responsibility for reviewing mental impairments in the State agency.

\* \* \* \* \*

**Subpart N—[Amended]**

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

**Authority:** Secs. 702(a)(5), 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1383, and 1383b); sec. 202, Pub. L. 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

16. Amend § 416.1441 by revising paragraphs (b)(3) and (b)(4), and by adding a new paragraph (b)(5) to read as follows:

**§ 416.1441 Prehearing case review.**

\* \* \* \* \*

(b) \* \* \*

(3) There is a change in the law or regulation;

(4) There is an error in the file or some other indication that the prior determination may be revised; or

(5) An administrative law judge requires the services of a medical expert to assist in reviewing a mental disorder(s), but such services are unavailable.

\* \* \* \* \*

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