CHILDHOOD QUESTIONS AND ANSWERS

GENERAL OVERVIEW: TOPIC ORGANIZATION

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This compendium includes:

- Qs&As that originally appeared in tab E in the Training Manual (SSA Pub. No. 64-081) for the December 2000/ January 2001 Childhood Disability Evaluation Training.
- Qs&As raised before and during the February 1, 2001 IVT broadcast.
- Still-relevant Qs&As from the 1997 Childhood Training. These Qs&As were updated and edited for clarity. The rest of the 1997 training manual is redundant or outdated and should no longer be used.

At the beginning of each section, we provide a list of Qs&As that appears in it. As further questions are received and answered, they will be added to this compendium and posted on PolicyNet, under "Special Purpose Areas," in "SSI Childhood Reference Materials."

All questions that previously appeared in the December 2000/January 2001 Student Manual or the 1997 Training Manual are marked with an asterisk (*).

As suggested by several users, we will shortly create a version of this compendium with hyperlinks; e.g., between the questions listed under each topic and their answers; between each index entry and the answers cited. Other suggestions to improve the usability of this compendium are welcome.

Topic I: Applying the Final Rules

I-1.* Why were the childhood rules changed and what are the changes based on? (12/00, Q2)
I-2.* Do the final rules change the statutory standard for childhood disability? (12/00, Q1)
I-3. Do the final rules change the sequential evaluation process?—
I-4.* When do we start using the new rules? (12/00, Q3)
I-5.* What happens to cases in the pipeline? (12/00, Q4)
I-6. What should an administrative law judge (ALJ) do when a court orders the judge to use the old rules for part or all of the period?
I-7.* Will we have to readjudicate cases using the final rules? (12/00, Q5)
I-8.* What effect will the final rules have on the number of allowances and denials? (12/00, Q9)
I-9.* Do the final rules require more case development? (12/00, Q10)
I-10.* Do the final rules apply to title II disabled child claims? (1997)
I-11. Do the final rules affect age-18 redeterminations?
I-12. Do the final rules have any special implications for prototype states?
I-13.* Do the process unification SSRs and training apply to these cases? (1997)
I-14. Can we use the functional equivalence domains at Step Two to determine whether the child has a severe impairment(s)?
I-15. Are we required to make a finding about the credibility of an individual's statements about symptoms for all cases or only functional equivalence (FE) cases?
I-16. We followed the IVT training pretty closely, but we want to know more. What do we do next?

Answers

I-1.* Why were the childhood rules changed and what are the changes based on? (12/00, Q2)

The revisions were based on:

- Public comments on the interim final rules;
- Our experience doing cases under the interim final rules;
- The results from the Commissioner's top-to-bottom review and re-reviews;
- Longstanding agency guidance previously issued in, e.g., training manuals, Program Operations Manual System (POMS), Social Security Rulings (SSRs); and
- Information we obtained from individual experts (including pediatricians, psychologists, other pediatric specialists and individual advocates for children with disabilities who have expert knowledge about the Supplemental Security Income (SSI) program).

We revised the rules because it was apparent from public feedback and our own experience that they were too complicated in places, or hard to understand, or did not include some guidance that we issued elsewhere.

I-2.* Do the final rules change the statutory standard for childhood disability? (12/00, Q1)

No. These rules use the same “listing-level” standard for determining disability as in the 1997 interim final rules. A child’s impairment(s) must meet, medically equal, or functionally equal the listings to be found disabling. For functional equivalence, this means the child’s impairment(s) must result in “marked” limitations in two domains of functioning or an “extreme” limitation in one domain.

I-3. Do the final rules change the sequential evaluation process?

No. The training emphasized functional equivalence and factors we need to consider when evaluating childhood claims because those parts of the rules changed. However, the steps in the sequential evaluation did not change at all. The steps are still:

Step 1: Is the child engaging in SGA?
Step 2: Does the child have a medically determinable impairment(s) that is “severe”?
Step 3: Does the child’s medically determinable impairment(s) meet, medically equal, or functionally equal the listings?

In the training, we talked about factors we must consider when evaluating the child’s ability to function and we reminded adjudicators that these factors apply throughout sequential evaluation whenever functioning is an issue. For example, deciding whether an impairment(s) is “severe” requires us to consider its functional impact, i.e., whether it causes more than minimal functional limitations. Similarly, many listings include functional severity criteria.

I-4.* When do we start using the new rules? (12/00, Q3)

The revised final rules became effective on January 2, 2001.

I-5.* What happens to cases in the pipeline? (12/00, Q4)

Use the new rules for **all** childhood cases. We explained in the preamble to the final rules that, as of January 2, 2001, the revised final childhood rules apply to all childhood cases pending at any stage of our administrative review process. This includes claims that are pending administrative review after remand from a Federal court (DI 25201.001C; 65 FR 54747, 54751) and cases in which part or all of the period at issue precedes January 2, 2001.

However, see the next question on processing cases in which a court instructs otherwise.

I-6. What should an administrative law judge (ALJ) do when a court orders the judge to use the old rules for part or all of the period?

Follow the court’s instructions and do what the court says.

I-7.* Will we have to readjudicate cases using the final rules? (12/00, Q5)

No. We are not required to rework any cases done under the interim final rules using these revised final rules.

I-8.* What effect will the final rules have on the number of allowances and denials? (12/00, Q9)

We expect there will be a slight increase in allowances. Determinations should be the same under the interim final and the revised final rules, but we expect there will be somewhat fewer erroneous determinations (allowances and denials) under the new rules because they simplify adjudication. The net effect should be some more allowances.

I-9.* Do the final rules require more case development? (12/00, Q10)

No. The revised final rules require the same sorts of evidence that were needed for adjudication under the interim final rules. We clarified and revised the rules to focus more attention on the "whole child," on the child's activities, and on the factors that must be considered in evaluating the child's impairment(s). These changes affect how we evaluate the evidence, not the amount or kind of evidence we need.

I-10.* Do the final rules apply to title II disabled child claims? (1997)

No. The 1996 law and the final rules apply only to title XVI (SSI) childhood disability claims. This is the same as it was before the law changed. Of course, the guidance we provide on factors to consider when evaluating functioning and sources of evidence is useful whenever we assess functioning in any claim under any title.

I-11. Do the final rules affect age-18 redeterminations?

The final rules do not affect the standard to be applied in evaluating age-18 redetermination cases. Age-18 redeterminations are evaluated using the adult initial claims standard, except for step 1, the substantial gainful activity step (§ 416.987; DI 23570.010). The only substantive change the final rules made to the age-18 redetermination process was to change the time frames in which the redeterminations may be performed. This change reflects the amendment made to this provision of the law by the Balanced Budget Act of 1997.

I-12. Do the final rules have any special implications for prototype states?

No. There is nothing special to do about childhood cases in prototype states. Just remember that all childhood determinations performed on and after January 2, 2001, must use the final childhood rules for the entire period at issue, including the period that preceded January 2. (See also Question I-5 about pipeline cases.) The final rules do not change the statutory requirement that we must make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the child's disability evaluates the case.

I-13.* Do the process unification SSRs and training apply to these cases? (1997)

Yes. The new childhood rules do not alter any process unification requirements. All of the SSRs that pertain to the evaluation of symptoms and medical source opinion in adults and children continue to apply, except to the extent that they refer to provisions of prior law (e.g., the individualized functional assessment).

I-14. Can we use the functional equivalence domains at Step Two to determine whether the child has a severe impairment(s)?

This is acceptable, but it is usually not necessary. Step Two of sequential evaluation does not require as extensive an analysis as functional equivalence. The purpose of Step Two is to decide whether the impairment(s) is more than a slight abnormality, or a combination of slight abnormalities, that causes more than minimal functional limitations (DI 25220.005; § 416.924(c)). However, if adjudicators find it useful, it is permissible to use the functional equivalence domains at this step.

I-15. Are we required to make a finding about the credibility of an individual's statements about symptoms for all cases or only functional equivalence (FE) cases?

The new childhood rules do not alter our policy on the evaluation of symptoms. When we cannot make a fully favorable determination based solely on the objective medical evidence, we must assess the extent to which the child's statements about the functional effects of his or her symptoms. (If a child is unable to adequately describe his or her symptoms, we will accept as a statement of the symptoms the description given by the person who is most familiar with the child, per DI 25205.001A.3. and § 416.928(a).) The issue whether symptoms have an impact on the determination or decision and, therefore, whether we need to make a finding about credibility, is not confined to the functional equivalence step. It may occur at any part of the sequential evaluation process beginning with whether the impairment is "severe" and including "meets" and "medical equivalence" depending on the listing involved.

Also, remember two things:

- As explained in the past, we do not require use of the word "credibility" when we make our finding about symptoms.
- Per DDS Administrators' Letter No. 553, no formal credibility finding is needed on any case in which the DDS awards disability from the onset date that the claimant alleged (a fully favorable determination). Subsequent reviewers must be able to determine whether the allowance was based solely on objective medical evidence or whether the decisionmaker assessed credibility.

I-16. We followed the IVT training pretty closely, but we want to know more. What do we do next?

For questions about **how** to apply the final rules, refer to the regulations first – they include much more detail than we were able to provide during the training sessions. To learn more about **why**

we revised the regulations the way we did, read the preamble on pages 54747-54775 of the *Federal Register*. The preamble explains the rules and also answers many questions in the Public Comments section starting on page 54760.

The complete childhood regulations, including both the revised and unrevised provisions, and the preamble, are in DI 25200. The revised material only is in the *Federal Register*, starting on page 54776, and corrected at 65 FR 80307 (12/21/2000). (Because it includes revised material only, the *Federal Register* version must be read in conjunction with the other relevant rules in 20 CFR Part 416, Subpart I.) The *Federal Register* is in Tab C of the December 2000/January 2001 Student Manual, and is also posted on PolicyNet, under “Special Purpose Areas,” in “SSI Childhood Reference Materials.” The PolicyNet site also includes the IVT script, material from the Student Manual, and related childhood issuances such as recent EMs and memorandums.

Topic II: Processing Childhood Cases

II-1. Can we still use earlier training manuals?
II-2.* Do the Disability Digests continue to apply? (12/00, Q40 & 1997)
II-3. Is the guidance in SSR 98-1p about cognitive and speech limitations that medically equal listing 2.09 still in effect?
II-4. Will the agency revise any notices?
II-5. EM- 00187 said to use medical list number (MLN) 107.30 in block 23 on the SSA-831 and block 12 on the SSA-832 for functional equivalence allowances and continuances, but that was only supposed to be until mid-February. What do we put in those blocks on the SSA-831 and SSA-832 now?
II-6. Is there a "grace period" on errors?
II-7. What quality reviews are planned?
II-8. Do the final rules affect the way we adjudicate SSI claims for children under Acquiescence Rulings (ARs)?
  II-8a. How should we apply the *Chavez* AR when adjudicating a child's SSI claim?
  II-8b. How should we apply the *Albright* AR when adjudicating a child's SSI claim?
  II-8c. How should we apply the *Drummond* AR when adjudicating a child's SSI claim?
II-9. Will we need to use more consultants to determine each case?
II-10.* What are the Individualized Family Service Plan (IFSP), the Individualized Education Program (IEP) and the IEP statement of transition service needs and how do we use them? (12/00, Q16)
II-11. Is it correct to say that information from early intervention programs and schools is now more important to help adjudicate cases?
II-12.* Why do we need to request information from early intervention and pre-school programs? (12/00, Q17)
II-13.* If school information is not readily available, especially during summer months, should we hold a case for this functional information? (1997)

Answers

II-1. Can we still use earlier training manuals?

The March 1998 Childhood Training Manual (it has a pink cover) is still relevant for childhood adjudication because it provides guidance for evaluating mental retardation (MR) and behavioral issues. Adjudicators should refer to that manual when they have questions about MR or behavioral disorder cases. Information from that manual will appear as a Social Security Ruling (SSR).

Some still-relevant questions from the 1997 Childhood Training are incorporated into this Q&A document although they were updated and edited for clarity. The rest of the 1997 Training Manual is redundant or outdated and should no longer be used.

II-2.* Do the Disability Digests continue to apply? (12/00, Q40 & 1997)

Some do and others do not:

- Digests about policies that have not changed still apply.
- Digests about broad development or evaluation issues are likely to remain useful.
- Digests about the previous functional equivalence domains no longer apply.
- Digests about the prior individualized functional assessment (IFA) have been obsolete since August 22, 1996, when P.L. 104-193 was enacted.

For example, Disability Digest 92-8 provides guidance about a rule that hasn't changed. It discusses the "major congenital organ dysfunction" example of functional equivalence (now in DI 25225.060; § 416.926a(m)(9)) and the part concerning listing-level severity remains useful, but not the IFA part. Similarly, Digest 93-7 discusses evaluation of cases in which the child exhibits high blood lead levels; Digest 94-1 concerns the development requirements for establishing the existence of an impairment. Both of these still apply.

We plan to compile the still relevant information from the Digests into at least one SSR.

II-3. Is the guidance in SSR 98-1p about cognitive and speech limitations that medically equal listing 2.09 still in effect?

Yes. We can still find medical equivalence to Listing 2.09 when a child has marked limitations in both cognition and speech, as explained in the SSR, with one change:

The guidance in the SSR about comparing the child's speech to his or her cognitive age has been superseded by the more general principle stated in the final rules that we compare a child's functioning to that of other children the same age who do not have impairments. So to determine whether there is a marked limitation in speech, use Table 1, but do not use the guidance about comparing to cognitive age for children who are less than 8 years old. In other words, always use the child's chronological age.

Note that this does not change our longstanding instructions about Listings 112.05D. and F., which (in addition to mental retardation and "marked" limitation in cognition/communication) require "a physical or other mental impairment imposing additional and significant limitation of function." To decide whether a child with mental retardation and speech problems satisfies this criterion, we need to decide if the child has a separate medically determinable impairment that affects speech. When it is not obvious whether there is a separate impairment (e.g., no congenital disorder resulting in speech problems), we still need to compare the child's speech to his or her cognitive level to decide whether there is a separate speech impairment.

See also Question VI-D3 for other guidance for using SSR 98-1p.

II-4. Will the agency revise any notices?

No. We have reviewed the preprinted DDS and OHA notice language and believe that they are sufficient in their present form, and will not require revision to reflect changes in the final rules.

II-5. EM- 00187 said to use medical list number (MLN) 107.30 in block 23 on the SSA-831 and block 12 on the SSA-832 for functional equivalence allowances and continuances, but that was only supposed to be until mid-February. What do we put in those blocks on the SSA-831 and SSA-832 now?

It is not necessary to record anything in those blocks, but no edit will result if the adjudicator does. The 107.30 MLN entry for functional equivalence allowances and continuances was solely to satisfy a systems requirement. Per EM-01043, issued March 7, 2001, the Office of Systems changed the requirement and no MLN entry at all is required for functional equivalence allowances and continuances. EM-00187 is now obsolete.

No MLN is necessary because functional equivalence has been delinked from reference to any particular listings. This includes the functional equivalence examples in § 416.926a(m) and DI 25225.060.

An MLN entry of a specific Listing of Impairments section is still required in all meets/medical equals allowances and continuances (DI 26510.050).

II-6. Is there a "grace period" on errors?

Initial childhood cases are not being counted in DDS performance accuracy for the period of January 2, 2001 at least through April 30, 2001. At this time (05/09/2001), extension of the period during which childhood cases will not be counted is under consideration. (See ODPQ memo of 12/27/00 posted on PolicyNet, under "Special Purpose Areas," in "SSI Childhood Reference Materials.")

II-7. What quality reviews are planned?

The Office of Quality Assurance and Performance Assessment (OQA) has been reviewing a special sample of childhood cases each month to monitor implementation of the new final rules. OQA will select a random national sample of 1000 childhood cases per month in addition to the childhood cases in the regular QA sample. As data become available, OD and OQA will evaluate review results, and adjustments to the sample design and review procedures will be made as appropriate. (See ODPQ memo of 12/27/00 posted on PolicyNet, under "Special Purpose Areas," in "SSI Childhood Reference Materials.")

II-8. Do the final rules affect the way we adjudicate SSI claims for children under Acquiescence Rulings (ARs)?

Yes. The final rules for childhood disability affect the way we adjudicate a subsequent SSI disability claim of a child under the *Chavez*, *Albright* or *Drummond* ARs, each of which is discussed below.

II-8a. *Chavez* AR (See DI 32720.001 ff., AR 97-4(9))

When does the *Chavez* AR apply?

The *Chavez* AR applies to claimants residing in Alaska, Arizona, California, Guam, Hawaii, Idaho, Montana, Nevada, Northern Mariana Islands, Oregon or Washington at the time of the adjudication of a subsequent claim. It applies when:

- the claimant had a prior disability claim on which there was a final ALJ or AC decision which found the claimant **not** disabled; and
- the adjudicator is deciding a subsequent disability claim under the same title of the Act involving a period that was not adjudicated in the final ALJ or AC decision on the prior claim.

How should an adjudicator apply the *Chavez* AR when adjudicating a child's SSI claim under the final rules?

When adjudicating the subsequent claim involving an unadjudicated period, adjudicators will apply a presumption of continuing nondisability and determine that the claimant is not disabled with respect to that period, unless the claimant rebuts the presumption. A claimant may rebut the presumption by showing a "changed circumstance" affecting the issue of disability with respect to the unadjudicated period (see DI 32720.010 A.3.).

For purposes of the *Chavez* AR, the presumption of continuing nondisability is rebutted if the final ALJ or AC decision on the prior claim was made before January 2, 2001, and the decision found the claimant not disabled on the basis that the claimant's impairment(s) did not meet, medically equal, or functionally equal in severity a listed impairment in the Listing of Impairments.

If the presumption is rebutted for any reason, an adjudicator then must adopt prior findings required at a step in the sequential evaluation process for determining disability (see DI 32720.010B.1.b.) from the final ALJ or AC decision on the prior claim in determining whether the claimant is disabled with respect to the unadjudicated period unless:

- there is new and material evidence relating to the prior finding; or
- there has been a change in the law, regulations or rulings affecting the finding or the method for arriving at the finding.

For purposes of the *Chavez* AR, an adjudicator should not adopt an ALJ or AC finding that a child claimant's impairment(s) does not functionally equal the severity of a listed impairment, if the prior finding was made before January 2, 2001.

II-8b. *Albright* AR (See DI 52715.001 ff., AR 00-1(4))

When does the *Albright* AR apply?

The *Albright* AR applies to claimants residing in Maryland, North Carolina, South Carolina, Virginia or West Virginia at the time of the adjudication of a subsequent claim. It applies when:

- the adjudicator is deciding a subsequent disability claim with an unadjudicated period; and
- the subsequent claim arises under the same or a different title of the Act as a prior disability claim on which there has been a final decision by an ALJ or the AC.

How should an adjudicator apply the *Albright* AR when adjudicating a child's SSI claim under the final rules?

In applying the *Albright* AR when adjudicating a subsequent SSI disability claim of a child, an adjudicator will consider the prior ALJ or AC findings required at a step in the sequential evaluation process for determining disability (see DI 52715.010 B.1.b.) as evidence and give such findings appropriate weight in light of all relevant facts and circumstances in determining whether the claimant is disabled with respect to the unadjudicated period involved in the subsequent claim.

The weight to be given to a prior finding depends on the extent to which the prior finding has probative value in determining disability with respect to the period being adjudicated in the subsequent claim. In determining the weight to be given to a prior finding, an adjudicator will consider such factors as:

- whether the fact on which the prior finding was based is subject to change with the passage of time,
- the likelihood of such a change, considering the length of time that has elapsed between the period previously adjudicated and the period being adjudicated in the subsequent claim, and
- the extent that evidence not considered in the final decision on the prior claim provides a basis for making a different finding with respect to the period being adjudicated in the subsequent claim.

Under the *Albright* AR, an adjudicator should not give any weight to an ALJ or AC finding that the claimant's impairment(s) is or is not functionally equal in severity to a listed impairment if the prior finding was made before January 2, 2001.

II-8c. *Drummond* AR (See DI 52705.001 ff., AR 98-4(6))

When does the *Drummond* AR apply?

The *Drummond* AR applies to claimants residing in Kentucky, Michigan, Ohio or Tennessee at the time of the adjudication of a subsequent claim. It applies when:

- the adjudicator is deciding a subsequent disability claim with an unadjudicated period; and
- the subsequent claim arises under the same title of the Act as a prior disability claim on which there has been a final decision by an ALJ or the AC.

How should an adjudicator apply the *Drummond* AR when adjudicating a child's SSI claim under the final rules?

In applying the *Drummond* AR when adjudicating a subsequent SSI disability claim of a child, an adjudicator must adopt prior findings required at a step in the sequential evaluation process for determining disability (see DI 52705.010 B.1.b.) from the final ALJ or AC decision on the prior claim in determining whether the claimant is disabled with respect to the unadjudicated period unless:

- there is new and material evidence relating to such a finding; or
- there has been a change in the law, regulations or rulings affecting the finding or the method for arriving at the finding.

For purposes of the *Drummond* AR, an adjudicator should not adopt an ALJ or AC finding that a child claimant's impairment(s) does or does not functionally equal the severity of a listed impairment, if the prior finding was made before January 2, 2001.

II-9. Will we need to use more consultants to determine each case?

No. We hope that the new domains will help consultants evaluate the effects of impairments in their respective fields in all of the domains and this may result in fewer referrals for some cases. We did not change who is responsible for making determinations. It is possible that the clarifications in the final rules of how to consider multiple impairments will lead to more collaboration among medical and psychological consultants. However, the final rules did not change our existing rules on the qualifications of medical and psychological consultants and the types of cases that psychological consultants and medical consultants who are not physicians can evaluate. See DI 24501.001 and § 416.1016 concerning who can be a medical or psychological consultant in the DDS.

II-10.* What are the Individualized Family Service Plan (IFSP), the Individualized Education Program (IEP) and the IEP statement of transition service needs and how do we use them? (12/00, Q16)

Under Federal law, some children with physical or mental impairments receive early intervention or special education services. Receiving these services may be affected by factors unrelated, or

only partially related, to the child's level of limitation. Such factors can include the level of funding available in the specific facility, the preferences and views of school administrators or even individual teachers towards special education, and the child's personality.

Generally, children who are eligible for early intervention services (from birth to attainment of age 3) have an IPSP and older children (from age 3 and up) who are eligible for special education services have an IEP. For adolescents (age 14 and older), the IEP includes a plan for transition from school to post-secondary education, work and community living. These documents have two parts.

The first part analyzes the child's skills. The IFSP describes the young child's present development (e.g., physical, social), which must be based on professionally acceptable objective criteria, as well as a statement about how the child's impairment(s) affects his or her participation in activities. Similarly, the IEP describes the school-age child's present levels of educational performance (both strengths and weaknesses), including how the child's impairment(s) affects his or her involvement and progress in the general curriculum used for children without impairments. Both documents are important sources of information about the child's abilities and limitations in functioning and include information about factors that we also consider when evaluating children compared to children the same age who do not have impairments. For example, an IEP will describe the child's special education services and supplementary aids and also program modifications made to accommodate his or her impairments.

The second part of these documents identifies therapeutic or educational goals, including specific treatment or instructional methods to help the child achieve the identified objectives. As a student approaches high school completion, the IEP transition plan estimates the levels of functioning estimated as reasonable by the special education team and the student. These levels may range from supervised and supported work and living settings to independent work and living situations.

Either the IFSP or IEP can provide useful information about a child's functioning, but it is important to understand that the underlying purpose is not the same as ours in adjudicating disability claims. The IFSP or IEP identifies goals for improvement that it is hoped the child can accomplish. In contrast, we need to know more about what the child cannot do or has difficulty doing. However, these two concerns – potential accomplishments versus current limitations - are clearly related. For example, if an IEP goal is "will be able to read at 3rd grade level," we can safely conclude that the child was not performing at that level when the IEP was written.

Although the IFSP/IEP goals can help indicate current skill levels and limitations, it is important to remember that they are only anticipated outcomes. Although the child may ultimately accomplish those goals, we cannot presume that this will happen nor adjudicate based on that presumption.

II-11. Is it correct to say that information from early intervention programs and schools is now more important to help adjudicate cases?

No. Early intervention programs and schools have always been potentially rich sources of information about the child, and they still are. There is no change in the emphasis or role of information from these sources, such as the IFSP and IEP discussed in II-10 above.

Just as important as the IFSP or IEP is the comprehensive assessment that is done initially to identify a child with disabilities and then repeated periodically to assess the child's progress. By law, these assessments should occur at least once a year for children under age 3 and every three years for children age 3 and older. The law also requires periodic progress reports every 3 to 4 months for infants and toddlers and yearly for school-age children. The assessments are supposed to include the early intervention or special education team's findings and recommendations for the child's therapeutic or educational program.

As part of a comprehensive assessment, children should be given tests of aptitude and achievement, as well as clinical examinations, which convey valuable evidence about functional limitations. When a claimant's MDI can be established by a school psychologist or SLP, the current assessment may provide the primary evidence needed to evaluate the child's impairment(s) and resulting limitations. When requesting information from schools or early intervention programs, be sure to specifically ask for the most recent comprehensive assessment and test results and other evidence that supports the analysis of the child's skills. Note that not all school districts are able to do periodic assessments timely. Do not make any assumptions that a child’s condition has improved based on the **lack** of such an assessment.

II-12.*Why do we need to request information from early intervention and pre-school programs? (12/00, Q 17)

This is not a new requirement. Since 1991, we have asked for information about these sources on the SSA-3881 (Questionnaire for Children Claiming SSI Benefits) or the SSA-3820 (Disability Report – Child). More importantly, our guidance has always stressed the need for information about a child’s functioning from the people who see the child on a day-to-day basis, including early intervention and pre-school personnel. These sources may also have medical evidence to submit.

II-13.* If school information is not readily available, especially during summer months, should we hold a case for this functional information? (1997)

Not necessarily, but we have always allowed development to be deferred if there is no alternative. This may happen in some cases during the summer if a case cannot be decided based on the medical and other evidence in the case record.

Do not forget that there may be alternative sources of evidence. For example, information about children’s daily functioning compared to other children the same age who do not have impairments may be available from counseling, employment or recreation programs.

Also remember that school records may be available in the summer. Some special education students receive Extended School Year services usually involving therapies such as speech/language, occupational or physical therapy. These therapists can be good sources of current functional information. Other children may have summer school vocational programs that are not formal jobs that can provide useful information.

Topic III: Establishing Medically Determinable Impairments (MDIs)

III-1.* Why does the "nonsevere" step now also require a finding about the existence of a medically determinable impairment(s)? (12/00, Q6)
III-2. Does it matter why a child has a medically determinable impairment? For example, if family circumstances contribute to the child's condition, how do we evaluate that factor?
III-3.* What sources can establish the existence of a medically determinable impairment? (12/00, Q7)
III-4.* Who can submit evidence about the severity of an impairment(s)? (12/00, Q8)
III-5. How do we evaluate a child who is having trouble in school, but has no medically determinable impairment that explains his or her problems?

Answers

III-1.* Why does the "nonsevere" step now also require a finding about the existence of a medically determinable impairment(s)? (12/00, Q6)

This is not a new policy, but a statement of our longstanding practice. We stated this policy in SSR 96-4p, "Title II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations." (DI 24515.065; 61 FR 34488, July 2, 1996). In that SSR, we indicated "[I] n claims in which there are no medical signs or laboratory findings to substantiate the existence of a 'medically determinable physical or mental impairment,' the individual must be found not disabled at step 2 of the sequential evaluation process . . . ." This principle applies to children as well as adults.

At Step Two, an impairment or combination of impairments is considered "severe" if it is more than a slight abnormality (or combination of slight abnormalities) that causes more than minimal functional limitations. An impairment(s) that is "not severe" must be a slight abnormality (or a combination of slight abnormalities) that has no more than a minimal effect on a child's functioning (DI 25220.005; § 416.924(e)).

III-2. Does it matter why a child has a medically determinable impairment? For example, if family circumstances contribute to the child's condition, how do we evaluate that factor?

It is irrelevant why a child has a medically determinable impairment(s). The Social Security Act requires us to determine whether a child has such an impairment(s), and if so whether it causes marked and severe functional limitations. With the limited exception involving claims in which alcoholism or drug addiction is a contributing factor material to the determination of the disability, the Act does not allow us to disregard medically determinable impairments in determining whether an individual is disabled. The Act also does not allow us to discount any effects of a child's medically determinable impairment based on such factors as family circumstances.

III-3.* What sources can establish the existence of a medically determinable impairment? (12/00, Q7)

In June 2000, we published final rules that expand the list of "acceptable medical sources" (DI 22505.003B1; § 416.913(a)) and provide closely related information about who can be a medical or psychological consultant in the DDS (DI 24501.001; § 416.1016). The "acceptable medical sources" list now reads as follows:

(1) Licensed physicians (medical or osteopathic doctors);
(2) Licensed or certified psychologists. Included are school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, for purposes of establishing mental retardation, learning disabilities, and borderline intellectual functioning only;
(3) Licensed optometrists, for the measurement of visual acuity and visual fields;
(4) Licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle; and
(5) Qualified speech-language pathologists, for purposes of establishing speech or language impairments only. For this source, ``qualified'' means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of Clinical Competence from the American-Speech-Language-Hearing Association.

We determined that there is sufficient standardization of qualifications across the States to use these professionals to establish the existence of impairments within their disciplines. We have not done that for other professions such as pediatric nurse practitioners, audiologists or psychiatric social workers although we recognize that they are important sources of evidence for the disability adjudication.

These rules were effective on July 3, 2000. The text, including the preamble, is posted on PolicyNet, under "Special Purpose Areas," in "SSI Childhood Reference Materials; Related Material."

III-4.* Who can submit evidence about the severity of an impairment(s)? (12/00, Q8)

Once we establish the existence of a medically determinable impairment(s) based on evidence from an acceptable medical source, we consider all relevant evidence to help decide its severity (DI 22505.003B2 and DI 25210.001A; §§ 416.913(d) and § 416.924a(a)). Some of the sources whose evidence we consider in a child's case could include occupational, physical or rehabilitation therapists, audiologists, educators, early intervention specialists, public and private social welfare agency personnel, daycare workers, parents and other family members, other caregivers, friends, neighbors and clergy.

III-5. How do we evaluate a child who is having trouble in school, but has no medically determinable impairment that explains his or her problems?

To determine disability, we do not count limitations unless they result from a medically determinable impairment. This principle comes from the Social Security Act, and the final rules do not change this in any way. Regarding academic underachievement in particular, if it does not result from a medically determinable impairment, it cannot be considered (see Disability Digest 93-3, dated March 1993).

However, a child who is having significant but unexplained problems may have an impairment that has not yet been diagnosed, or may have a diagnosed impairment for which we lack evidence. For example, a child who is many grades behind in school is very likely to have a medically determinable impairment. In many cases the school will have evaluated the child and the school records will provide information about whether there's an MDI. Otherwise, we may need to get a CE. As always, we must pursue any indications that an impairment may be present if that fact may be material to the determination.

See also Question VI-B1 for further discussion about evaluating a child who has academic difficulties.

Topic IV: Considering Factors That Help Determine How Children Function

IV-1. When we rate limitations, how do we consider the child's ability to function independently?
IV-2.* Why do we have a specific factor about "extra help" since most children, including those without impairments, get help from their parents, teachers and others? (12/00, Q13)
IV-3.* Why am we required to consider how a child would function outside a structured or supportive setting? (12/00, Q14)
IV-4. If we have no information about how a child would function outside a structured setting or without extra help, how can we determine the extent of the child's limitation?
IV-5. What do the regulations mean by the reference to considering "the standards used by the person who gave us the information"?
IV-6.* What activities should we use to compare the functioning of children who have impairments with that of children who do not? (12/00, Q11)
IV-7. When evaluating a child who's in the 6th grade, but who functions like a 4th grader, what age group do we use when considering the child's ability to function?
IV-8.* Why do we need to know that a child may function differently in an unusual setting? (12/00, Q15)
IV-9. We were previously told that we should not punish a child for not taking medications. Does this mean that under no circumstances should we deny a child's eligibility if parents withhold treatment?
IV-10.*Why do the regulations emphasize the need to evaluate the combined effects of multiple impairments? (12/00, Q12)
IV-11. How do we consider the interactive and cumulative effects of impairments?
IV-12. When we rate the cumulative effects of impairments, how do we rate multiple impairments that are "not severe" in the same domain?

Answers

IV-1. When we rate limitations, how do we consider the child's ability to function independently?

Functioning independently is about doing age-appropriate activities in an age-appropriate manner, so we evaluate a child's independence in functioning by comparing his or her functioning to that of same-aged children who do not have impairments. Obviously, even typically developing younger children need some help with age-appropriate activities. So the question is: does the child we are evaluating need any form of assistance above and beyond what a child the same age without an impairment(s) would need?

To evaluate the extent to which a child's independent functioning is compromised by his or her impairment(s), we consider whether the child needs a person, a medication, a treatment, a device, or a setting to make functioning possible, or to improve his or her functioning. The more intensive or extensive the help received, the less independent the child is in functioning, and the greater weight this factor has in the rating of limitations.

- Assistance is **intensive** with respect to the kind of help received. For example, a child who is given a behavior modification plan in a regular classroom receives more intensive assistance than a child who has to be reminded once in a while to keep his voice down while walking in the halls.
- Assistance is **extensive** with respect to the number of times and settings in which the help is received. For example, a child who has a one-to-one aide in every academic subject is receiving more extensive assistance than a child who receives one-to-one help only in math.

A child may appear to function very well in a particular activity or set of activities. But if he or she requires extra assistance to do so, then the child is not functioning as independently as same-age children without impairments.

See DI 25210.020; § 416.924a(b)(5). See also Questions IV-2, IV-3 and IV-4 below regarding "extra help" and structured settings.

IV-2.* Why do we have a specific factor about "extra help" since most children, including those without impairments, get help from their parents, teachers and others? (12/00, Q13)

The key word is "extra." As with every other aspect of these rules, the guidance on "extra help" is based on comparing a child's functioning to that of children of the same age who do not have impairments. In other words, we consider the help a child needs to be "extra" only to the extent that it is more help than a child of the same age without an impairment would be expected to need (DI 25210.020B; § 416.924a(b)(5)(ii)).

The "extra help" rule is one of several factors we stress in these regulations to focus on the big picture of a child's functioning. The point is that a child who is "able" to function may need so much assistance in doing so that the need indicates a limitation. Both the extent of extra help and the response to it are important factors to consider. If the assistance required is significant, this may indicate the presence of a marked or extreme limitation.

A real life example that we used in the 1998 training concerned a 9-year-old who had in the past injured himself, his classmates, and his family. To prevent more such behavior, this child required "wraparound" services; i.e., a person who stayed with him most of the time to make sure he did not do any further harm. Because the child had not injured anybody recently, the adjudicator did not establish an extreme limitation. But when we step back and consider the extraordinary help the child needed to keep him from injuring himself or someone else, it should be evident that the child had a very serious (i.e., extreme) limitation.

In making the disability determination or decision, we are required to assess how a child would function without the extra help.

IV-3.* Why am we required to consider how a child would function outside a structured or supportive setting? (12/00, Q14)

All children require structure and support, but children with impairments may require more structure and support to function than children of the same age without impairments. A child with an impairment(s) may be able to perform activities that are typical for his or her age group only because he or she gets high levels of personal attention, support, monitoring or discipline in a structured or supportive setting.

We must compare the child's functioning to that of children the same age who do not have impairments, and children without impairments function without the sorts of unusual structure and support described above. Therefore, to properly evaluate the child's functioning we must know how he or she functions, or would function, outside of such settings (DI 25210.020D; § 416.924a(b)(5)(iv)).

For example, a child in special education classes may function well in that context, but we must assess how the child functions, or would function, in ordinary settings in a mainstream classroom. A child with serious behavior problems may function well within a structured setting, but the behavior may not be controlled outside of such a setting. This may indicate the presence of limitations in one or more domains although the child does not show those limitations (or does not show them to their full degree) because of the structured classroom setting.

In making the disability determination or decision, we are required to assess how a child would function without the structured or supportive setting and use those findings to assess whether the child's limitations are marked or extreme.

IV-4. If we have no information about how a child would function outside a structured setting or without extra help, how can we determine the extent of the child's limitation?

If we have no "outside" information because the child is always in a structured setting in excess of what would be expected for children the same age who do not have impairments, that fact alone tells us that the child is probably quite limited.

Also, information about the structured setting itself, or about the kind of extra help the child receives, can tell us something about how a child would likely function outside the setting or without the help. Such information could tell us about:

- The intensity of the structured setting. For example, a ratio of one adult to three or four students suggests a very highly structured setting.
- The time requirement, or how long, the child needs to be in a structured setting. Our old example of the child who needs 24-hour wraparound services illustrates a very serious condition. Even somewhat less than that could be very serious.

- The amount of help provided. For example, a child who needs someone to act as an individual aide for all classroom work clearly has little independence in some skills needed for acquiring and using information.

On the other hand, if we have no other information because the case development did not cover the parts of the day when the child is not in a structured setting, more development may be necessary. In any case, school records and assessments will very often explain why a child receives special assistance (e.g., special education classroom or extra help) and this information may help us evaluate how the child would function in less supportive settings.

IV-5. What do the regulations mean by the reference to considering "the standards used by the person who gave us the information"?

We compare a child's functioning to the functioning of other children the same age who do not have impairments, so we need to know whether that is the standard of comparison used by any source of information. For example, if a special education teacher says a child is "doing well," without indicating whether she means doing well compared to her expectations for the child, or compared to other children in the special education class, or compared to children the same age who do not have impairments (which is what we need), we need to clarify the teacher's response. See DI 25210.010B and § 416.924a(b)(3).

IV-6.* What activities should we use to compare the functioning of children who have impairments with that of children who do not? (12/00, Q11)

Use any and all activities appropriate for the child's age. We designed the new rules to help adjudicators consider what children do and do not do every day at home, in school and in the community. The domain descriptions in DI 25225.030 - .050 and § 416.926a(g)-(k) include examples of activities that illustrate the typical functioning of children in different age groups. (We did not provide such descriptions for the sixth domain, "Health and physical well-being," which does not lend itself to descriptions of "typical" activity. As we did for all the other domains, however, we included examples of limitations in this domain (DI 25225.055B; § 416.926a(l)(4))). The critical issue is to evaluate what the child can and cannot do, is limited or restricted in doing, how much help the child needs, and so on to develop a picture of the "whole child." Then we can assess how the child functions compared to children the same age who do not have impairments.

IV-7. When evaluating a child who's in the 6th grade, but who functions like a 4th grader, what age group do we use when considering the child's ability to function?

A basic principle of the final rules is that we must always compare a child's functioning to that of other children who are the same chronological age who do not have impairments.

IV-8.* Why do we need to know that a child may function differently in an unusual setting? (12/00, Q15)

It is a well-known clinical phenomenon that children with some impairments, for example attention-deficit/hyperactivity disorder (ADHD), may be calmer, less inattentive, or less out-of-control when in a novel or one-to-one setting such as a consultative examination. So a CE provider may observe and report a degree of attentiveness or lack of hyperactivity in a child with ADHD that is in stark contrast to parents' and teachers' reports that the child has great difficulties. This does not necessarily represent a conflict in the evidence; it is a fairly typical scenario for a child with ADHD.

This example highlights the importance of our emphasis on getting a full picture of the whole child, and of our longstanding policy that no single piece of evidence should be considered out of the context of the remainder of the case record. Accepting the observation of the child's behavior or performance in an unusual setting without considering the rest of the evidence could lead to an erroneous conclusion about the child's overall functioning.

See DI 25210.025 and § 416.924a(b)(6).

IV-9. We were previously told that we should not punish the child for not taking medications. Does this mean that under no circumstances should we deny a child's eligibility if parents withhold treatment?

SSA policy is that we do not consider a disabled child under age 18 fully responsible for failing to follow prescribed treatment. While the "failure to follow prescribed treatment" policy can apply in childhood cases, we do not expect it will apply very often. Remember that it is not even considered unless we find the child disabled **and** that treatment was prescribed by the child's treating source that can be clearly expected to result in the child no longer being disabled. Even then, "good cause" for the failure to follow treatment must be considered; e.g., if the child's caregiver has found the side effects of treatment unacceptable, we would find good cause, and not deny or cease eligibility for failure-to-follow. However, if good cause is **not** found and all the other requirements are met, a failure-to-follow denial would be appropriate per § 416.930 and DI 23010.005 ff. Also see SSR 82-59 and Disability Digest 94-7.

IV-10.*Why do the regulations emphasize the need to evaluate the combined effects of multiple impairments? (12/00, Q12)

The law requires us to consider the combined effects of all of an individual's impairments in determining whether the individual is disabled, without regard to whether any impairment, considered separately, would be of sufficient severity to find the individual disabled. The interim final rules and our other instructions reflected that principle. However, we found through experience and the public comments that we needed to explain the requirement better. The revised final rules in DI 25210.015 and § 416.924a(b)(4) are intended to emphasize that limitations resulting from a combination of impairments may be greater than the limitations we would expect if we look separately at each impairment.

There is a closely related rule in DI 25225.010 and § 416.926a(c) concerning the interactive and cumulative effects of an impairment or multiple impairments which makes two important points:

- Any given activity may involve the use of multiple skills and abilities, so any limitation may result from the interactive and cumulative effects of one or more impairments.

- Any given impairment or combination of impairments may affect more than one domain.

So it is always important to consider possible limitations of function in each domain.

IV-11. How do we consider the interactive and cumulative effects of impairments?

Considering the "interactive and cumulative effects" of an impairment or combination of impairments is critical to determining functional equivalence. We have made it easy for adjudicators to account for those effects. If we carefully identify all of a child's limited activities and the domains involved in doing those activities, we will **automatically** consider all the interactive and cumulative effects of a child's impairment or combination of impairments.

The example on page 34 of Tab A in the December 2000/January 2001 Training Manual sorts out the activity of shoe tying by identifying the abilities needed to do it. This example illustrates that to do one seemingly simple activity, a child may have to use abilities in several domains. This is the heart of the matter: Many activities require the interaction of several abilities, and often a single impairment or combination of impairments may affect more than one ability. By identifying the abilities and domains involved in a child's doing any particular limited activity, we automatically do two things:

- Account for the interaction of abilities in the child's activities; and
- Account for the interactive and cumulative effects of an impairment or a combination of impairments on those activities and abilities.

Here's how we do this:

Profile the child's activities

Profiling the child's activities is a descriptive task that does not require a judgment about the severity of the limitations. Keep in mind:

- The six questions about a child's activities on Page 33 under Tab A in the Training Manual will help us collect clinical and lay descriptions of how the child functions – at home, school and in the neighborhood or community.
- Describing activities means identifying the activities the child can do, cannot do or does poorly.
- Statements should describe activities rather than draw conclusions. For example, a statement such as, "The child is impulsive," doesn't tell much about the child's activities compared to "The child grabs stuff, talks out of turn and runs into the street without looking." Do not state conclusions without citing concrete examples from the case record that support them.

Consider factors

- We do not have a complete profile of the child's activities until we consider what the case-related factors tell us about the quality (e.g., independence) of the child's functioning compared to that of other children the same age who do not have impairments.
- Consider all the factors listed in the regulations and POMS to see if they help us rate severity. For example, a child who needs extra help with an activity or who can learn only in a highly structured setting does not function as independently as other children the same age who do not have impairments.

Sort activities across domains

We sort activities by asking, "What does it take to do the activities the child can't do or does poorly?"

- For example, think about an adolescent who can not take a public bus across town to get to her practice work experience. Consider what's involved in doing this activity. She has to know how, where and when to catch the bus; which bus to ride; how to pay and how much; how to behave appropriately at the stop and on the bus; how and where to get off. She also has to physically get on and off the bus and practice safety rules.
- What does it take to do the things identified in taking the bus? Which abilities do the adolescent use and which domains are involved? She must use certain abilities in several domains, including: "Acquiring and using information," "Interacting and relating with others," Moving about and manipulating objects" and "Caring for yourself."
- In this example, suppose there is no allegation or evidence that suggests the adolescent has difficulty moving about or interacting and relating with others; that means we do not have to connect this difficulty in taking the bus to those domains.
- But suppose we have evidence of her difficulty learning and taking care of herself; that means we need to connect the activity to two domains, "Acquiring and using information" and "Caring for yourself" and indicate this on the SSA-538.

It is important to understand that connecting the same activity to two or more domains does **not** "double-weight" the activity. By recognizing that the adolescent has difficulty with at least two abilities necessary to the activity of taking a bus, we automatically account for the interaction of her abilities and the interactive effects of her impairments.

Does the child have a medically determinable impairment or a combination of impairments that accounts for the limitations?

We count limitations only when they result from the child's medically determinable impairment(s). (See also Question III-3 on what sources can establish the existence of an MDI.)

- If the child's impairment or combination of impairments affects the domain(s) where we recorded limited activities, then we have probably answered this question.

- When we answer this question, we should include in our considerations any impairment(s) (or combinations) that are "not severe."
- It may help to think about whether the child's impairment(s) **could** affect the abilities in a given domain. For example, some mental disorders, in and of themselves, would not be expected to affect a child's physical ability to move about and manipulate objects. If the medically determinable impairment(s) does not affect a domain in which some of the child's activities are limited, consider whether the limitations are attributable to some cause other than the child's impairments or determine if there is another impairment not documented by an acceptable medical source in the case record.

Rate the severity of the impairment-related limitations in each affected domain

Base a rating of severity on the magnitude or importance of the limited activity/activities as well as the quality of the limitations themselves.

- Review the definitions of "marked" or "extreme" limitation and the additional guidance about the definitions in the regulations and POMS.
- Remember: A child may have "marked" or "extreme" limitation in a domain based on only a single activity or based on several activities taken all together.

IV-12. When we rate the cumulative effects of impairments, how do we rate multiple impairments that are "not severe" in the same domain?

See the answer to Q IV-11, which explains how we consider the interactive and cumulative effects of impairments. This includes combinations of "severe" and "not severe" impairments and combinations of "not severe" impairments.

Topic V: Using Functional Equivalence Rules

V-1.* Who makes the finding of functional equivalence? (1997)
V-2. In OHA, is an updated medical opinion required to make a determination of functional equivalence?
V-3.* Why were the four functional equivalence methods replaced with only one? (12/00, Q18)
V-4. Have we returned to the old individualized functional assessment (IFA)? (12/00, Q19)
V-5.* Why are the functional equivalence domain names different from the ones used to evaluate childhood mental disorders? (12/00, Q20)
V-6.* How do the new domains avoid the previous concerns about possibly "double weighting" the same impairments? (12/00, Q21)
V-7. Does "delinking" functional equivalence from the listings mean we do not need to establish a medically determinable impairment for functional equivalence (FE) cases?
V-8.* Why are there still functional equivalence examples? (12/00, Q30)
V-9.* Can a mental impairment functionally equal the listings? (12/00, Q29)
V-10. When a child's mental impairment(s) does not meet or medically equal a mental listing, do we need to begin the process again to evaluate the functional equivalence domains?

Answers

V-1.* Who makes the finding of functional equivalence? (1997)

In the DDS, the State agency medical or psychological consultant has the overall responsibility for making the finding. (See Topic IX on completing the SSA-538. Also see DI 24501.001 and § 416.1016 concerning who can be a medical or psychological consultant in the DDS.)

For cases decided by a disability hearing officer, the disability hearing officer has responsibility for the finding or, if the disability hearing officer's reconsideration determination is changed under § 416.1418, the Associate Commissioner for Disability or his or her delegate has the responsibility. For cases at the OHA level, the responsibility lies with the ALJ or the Appeals Council. See DI 25225.065. and § 416.926a(n).

V-2. In OHA, is an updated medical opinion required to make a finding of functional equivalence?

No. The regulations and Social Security Ruling 96-6p (61 FR 34466, July 2, 1996) do not requires a medical opinion from a physician or psychologist designated by the Commissioner when deciding functional equivalence. Therefore, ALJs and Administrative Appeals Judges (when the Appeals Council makes a decision) are not required to obtain updated opinions when they find that that a child's impairment(s) functionally equals the listings.

V-3.* Why were four functional equivalence methods replaced with only one? (12/00, Q18)

We made the replacement primarily because public commenters and many adjudicators asked us to simplify and clarify these rules. In the 1997 interim final regulations we expanded the functional equivalence rules to incorporate guidance from our operating instructions, but it was

apparent from the large number of public comments and our experience adjudicating cases that we needed to do more to make the policy easier to apply.

But there were many specific reasons for the change. For example, we removed the method that involved assessing a “limitation of a specific function” (such as walking) because it was redundant: It could have been translated to a limitation in one of the domains (in the case of walking, the former “motor” domain, now “Moving about and manipulating objects”). We also simplified the policy by “delinking” it from reference to specific listings. Many adjudicators and others said that it was difficult to search through the listings to find ones that contained “disabling functional limitations.” We explain other reasons for making the change in the preamble to the final rules (DI 25290.075 – 25290.080; 65 FR at 54755-54756).

Although we removed the episodic impairments and limitations related to treatment or medications methods for establishing functional equivalence, we retained critical guidance from those two methods in the domains and in some of the other rule changes. (DI 25210.001 ff., DI 25225.001 ff.; §§ 416.924a and 416.926a).

V-4.* Have we returned to the old individualized functional assessment (IFA)? (12/00, Q19)

No. Some people ask this question because the new final rules emphasize the need to assess a child’s functioning compared to that of children the same age who do not have impairments (i.e., age-appropriate functioning) and to consider how well a child initiates, sustains, and completes tasks (i.e., performs tasks independently and effectively). The rules also include six domains of functioning, like the IFA.

However, the IFA was based on the prior legal standard of "comparable severity," which provided a lower severity threshold under which a child generally, though not invariably, could be found disabled based on “moderate” limitations in three domains or a “marked” limitation in one domain and a “moderate” limitation in another. The law now requires a standard of listing-level severity; i.e., “marked” limitations in two domains or “extreme” limitation in one domain.

The final rules state that we must consider a child’s functioning compared to other children the same age who do not have impairments because there is no other meaningful way to describe a child’s functional limitations. To know if a child is limited, we must refer to the functioning that would be expected for the child’s age. Our functional equivalence rules always required this consideration, although it is more clearly expressed in the final rules.

Likewise, we must consider the quality and independence of the child’s functioning. “Initiating, sustaining, and completing” tasks simply describes the three major aspects of doing any task that we should look at because any one of these abilities might be impaired.

The fact that there were six domains in the former IFA is a coincidence. The IFA domains were not the same as the functional equivalence domains in the final rules. We added a sixth domain, “Health and physical well-being,” in the final rules because of public concerns and questions we received from adjudicators about how to “fit” some physical manifestations of impairments into

the areas of functioning used in the interim final rules. We agreed with many commenters who urged us to include more guidance on assessing the physical effects of impairments and we also wanted to retain some guidance from the prior functional equivalence methods when we simplified the process to one method.

V-5.* Why are the functional equivalence domain names different from the ones used to evaluate childhood mental disorders? (12/00, Q20)

First, a frequent criticism of the old "broad areas of functioning" functional equivalence method was that the domains were "the same" as the domains in the mental disorders listings. The criticism was not accurate, but we agreed that using the same domain names could be confusing, especially when evaluating physical impairments.

Second, we revised the domains to more clearly delineate how a child functions, and devised new names that better describe this purpose. For example, we think it will be easier to understand what "Moving about and manipulating objects" means than the prior, more medical term "Motor functioning." But as we explained in the IVT training, the new domains are not just the old ones with new names. For example, the "Acquiring and using information" domain rates how the child thinks and learns, which is more than just assessing cognitive ability as measured by IQ tests.

V-6.* How do the new domains avoid the previous concerns about possibly "double weighting" the same impairments? (12/00, Q21)

The framework of domains for functional equivalence is based on a principle that enables us to evaluate the interactive and cumulative effects of impairments without double-weighting them. The principle is that each of a child's activities may involve more than one domain, because each domain represents distinct abilities, and a child typically uses more than one ability to do a given activity. So connecting one activity to two or more domains is not "double-weighting." It is the way we account for the interaction of the child's abilities and by the end of the evaluation process, also accounts for the interactive and cumulative effects of his or her impairment(s).

We assess a child's limitations in all domains affected by his or her impairment(s), but the effects we consider differ from domain to domain. For example, a child's ADHD may limit his or her ability to pay attention, which we consider under "Attending and completing tasks." Because of poor impulse control, the ADHD may also limit the child's ability to maintain friends, which we consider under "Interacting and relating with others."

The process of identifying a child's activities, the domains involved in doing them and the impairments that affect the domains does not result in double weighting. It is the means by which we achieve two important goals: evaluating the interactive and cumulative effects of multiple impairments AND multiple effects of single impairment(s). The key is that we should focus on the functional outcome of the impairment(s). This provides an easier way to assess how a single impairment can have effects in multiple domains and how multiple impairments can have combined effects in one or more domains.

See also Questions VI-C4 and VI-G2 for a discussion of the relationship between some major factors considered throughout sequential evaluation and specific domains that have similar characteristics.

V-7. Does "delinking" functional equivalence from the listings mean we do not need to establish a medically determinable impairment for functional equivalence cases?

No. There is no change in the statutory and regulatory requirement that disability be based on a medically determinable impairment or combination of impairments. Assuming the child is not engaging in SGA, the existence of a medically determinable impairment is the first thing we must establish in a disability claim. "Delinking" simply means that functional equivalence is now a freestanding way of evaluating whether a medically determinable impairment(s) is of listing-level severity. We no longer compare the child's impairment(s) to specific listings in the Listing of Impairments or refer to any particular listing.

This is why we no longer need a "medical list number" (MLN) on the SSA-831 or SSA-832 for functional equivalence allowances or continuances, including determinations based on the functional equivalence examples.

V-8.* Why are there still functional equivalence examples? (12/00, Q30)

We deleted two examples that were superseded by the changes in the functional equivalence rules. We believe the remaining examples are still useful because they provide a simple way to establish disability in some cases, and we would not want to remove these examples until we are sure the impairments they describe are covered by the listings.

V-9.* Can a mental impairment functionally equal the listings? (12/00, Q29)

Yes. A mental impairment that causes marked limitations in two of the 112.02B criteria (or extreme limitation in one) meets or medically equals a mental disorder listing. But under the final rules, a severe mental impairment may also functionally equal the listings.

Even under the prior rules, there were some cases for which functional equivalence was appropriate for evaluating the effects of a mental impairment(s). For example, there may have been cases of somatoform disorders that caused physical limitations of sufficient severity to have functionally equaled listings for physical impairments.

V-10. When a child's mental impairment(s) does not meet or medically equal a mental disorder listing, do we need to begin the process again to evaluate the functional equivalence domains?

Yes. One of the reasons we revised the functional equivalence domains the way we did is so that children with mental disorders would have a more meaningful opportunity for a functional equivalence evaluation.

Topic VI: Using Domains to Assess Children's Activities

A. General

VI-A1.* Must consultants in particular specialties or disciplines evaluate certain domains? For example, are there domains (e.g., Interacting and relating with others) that must always be rated by a psychiatrist or psychologist even if the only established impairments are physical? (12/00, Q22)
VI-A2.* What is the purpose of the lists of typical activities for children of different ages and the lists of limitations in the domain descriptions? (12/00, Q23)
VI-A3.* Must we develop evidence that addresses each of the examples of typical activities? (12/00, Q24)
VI-A4.* Should adjudicators still consider evidence about behavior? (12/00, Q33)
VI-A5. How should an adjudicator evaluate limitations due to a child's impulsivity?
VI-A6.* Where do we evaluate vision and hearing impairments that do not meet or medically equal a listed impairment? (12/00, Q28)

B. Acquiring and using information

VI-B1. Can academic difficulties alone constitute a marked or extreme limitation in "Acquiring and using information?"
VI-B2. Do we consider receptive language under "Acquiring and using information" and expressive language and articulation under "Interacting and relating with others?"

C. Attending and completing tasks

VI-C1. How do "Attending and completing tasks" and "Caring for yourself" apply to children under age 3?
VI-C2. Is "Attending and completing tasks" about completing age-appropriate tasks or completing tasks in an age-appropriate manner?
VI-C3. If a child has juvenile rheumatoid arthritis and has marked limitations in "Moving about and manipulating objects," can the child's slow handwriting also count as a marked limitation in "Attending and completing tasks?"
VI-C4.* What is the difference between the factor "How well [a child] can initiate, sustain and complete activities" and the domain "Attending and completing tasks"? (12/00, Q31)

D. Interacting and relating with others

VI-D1. Assume a child has a medically determinable personality disorder that is manifested by limitations in "Interacting and relating with others." The child demonstrates behavior that is destructive to others such as parents, teachers, bus drivers and coaches. Can a child qualify under the functional equivalence rules if there are no other relevant facts or circumstances?
VI-D2. The regulations incorporate language activities as part of "Interacting and relating with others." Please comment on why language is part of interacting and relating.

VI-D3. Does a “marked” or “extreme” limitation in speech under the tables in SSR 98-1p lead to a “marked” or “extreme” limitation in “Interacting and relating with others” even if all other aspects of that domain are less than marked?
VI-D4. What about the child who has a marked limitation in speech, but has normal pragmatic language abilities? Is “Interacting and relating” still rated as “marked?”
VI-D5. Under “Interacting and relating with others,” what do we mean by “the language of your community” as it pertains to a child who is non-English-speaking or who is bilingual?

E. Moving about and manipulating objects

VI-E1. Does “Moving and manipulating objects” cover the effects of mental impairments?

F. Caring for yourself

VI-F1. What is the scope of “Caring for yourself?”

G. Health and physical well-being

VI-G1.* Why is there a domain just for “Health and physical well-being”? (12/00, Q27)
VI-G2.* What is the difference between assessing the effects of chronic illness and treatment throughout the sequential evaluation process and assessing a child's “Health and physical well-being?” (12/00, Q32)
VI-G3. What is definition of “exacerbation” and how do we know when an episode begins or ends?
VI-G4. How do we distinguish “Moving about and manipulating objects” and “Health and physical well-being”?
VI-G5. Do we include episodes of ear infection, tonsillitis and leg pain in “Health and physical well-being”?
VI-G6. Does “Health and physical well-being” cover the effects of a mental impairment?
VI-G7. Should we rate asthma cases in “Health and physical well-being”?
VI-G8. The regulations describing the domain of “Health and physical well-being” list "psychomotor retardation" as a "physical effect" that should be considered under this domain. What does this mean?

Answers

A. General

VI-A1. Must consultants in particular specialties or disciplines evaluate certain domains? For example, are there domains (e.g., Interacting and relating with others) that must always be rated by a psychiatrist or psychologist even if the only established impairments are physical? (12/00, Q22)

No. We have never limited the task of rating any of the domains to any specialty or discipline. Medical consultants (MCs) and psychological consultants (PCs) should rate the effects of the

impairments they are evaluating in any and all domains affected, recognizing that any impairment can affect one or more domains. We believe that the final rules clarify this longstanding principle.

For example, a child with disfiguring burns may have social limitations resulting from the physical injuries and the necessary treatment. *Any* consultant evaluating the effects of the burns would rate those social effects in "Interacting and relating with others." Likewise, a child with pain may have difficulty concentrating because of the pain. The consultant should rate concentration difficulties in "Attending and completing tasks," regardless of the consultant's specialty or discipline.

Remember that the Social Security Act requires us to make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the child's impairment evaluates the case of the child. Non-physician consultants can evaluate only the effects of impairments within their disciplines, but in doing so, they must rate the effects of those impairments in all domains affected. Of course, if there are indications of a mental impairment, the case should be referred to a physician or psychologist, and if a mental-impairment determination is unfavorable, every reasonable effort must be made to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case.

VI-A2.* What is the purpose of the lists of typical activities for children of different ages and the lists of limitations in the domain descriptions? (12/00, Q23)

We believe that examples of "typical" childhood functioning will help provide a frame of reference for evaluating the degree of limitation in a child who is not functioning typically. The examples of limitations are largely drawn from training and case reviews, and we believe that they will be helpful in recognizing the sorts of problems a child may have in each domain. It is important to remember, however, that the lists aren't complete and that a child's limitations may be different from the ones listed in the examples. In keeping with our "one book" approach, we included as much information as possible within the regulations so that all adjudicators would have the same policy guidance and one place to refer to for information.

VI-A3.* Must we develop evidence that addresses each of the examples of typical activities? (12/00, Q24)

No. We specify in DI 25225.025 and § 416.926a(f)(3): "The examples are not all-inclusive, and we will not require our adjudicators to develop evidence about each specific example." Think of the examples as a way of providing a picture of how a child of a given age might look, and ways in which he or she might be limited. The relevance of the individual examples, and the development required, will depend on the particular child's case.

VI-A4.* Should adjudicators still consider evidence about behavior? (12/00, Q33)

Yes. The changes made by P.L. 104-193 in August 1996 eliminated certain specific references to "maladaptive behaviors" in the childhood mental disorders listings, but did not preclude consideration of the **effects** of such behavior on a child's functioning. Our childhood disability

training in March 1997 and March 1998 provided guidance on how to evaluate the effects of maladaptive behaviors, and also pointed out that medical sources consider such behaviors when diagnosing certain mental disorders. Under the final rules, we still consider maladaptive behaviors in the same two ways:

- Medically, to substantiate the presence of a particular disorder, because behaviors are often clinical signs; and
- Functionally, to assess the impact of such behavior on a child's functioning, especially in, but not limited to, the domain of Interacting and relating with others.

See the March 1998 Training Manual for more information, particularly pages 127 ff.

VI-A5. How should an adjudicator evaluate limitations due to a child's impulsivity?

We evaluate limitations resulting from impulsivity by profiling the child's activities, limitations in those activities and factors related to the limited activities. Impulsivity can interfere with a broad range of childhood activities. For example, impulsivity may interfere with activities involved in:

- Learning and thinking; e.g., a child repeatedly misreads words because of guessing based on the first letter or the shape of the word. We consider these limitations in "Acquiring and using information."
- Attending; e.g. a child carries out only the first part of a three-part instruction and then goes on to some unrelated activity. We consider these limitations in "Attending and completing tasks."
- Interacting; e.g., a child frequently approaches groups of children, interrupts whoever is talking, and interjects her own comment, question or story. We consider these limitations in "Interacting and relating with others."
- Taking care of oneself; e.g., a child dashes out into the street without looking, enters into dangerous interactions, or runs away from home without considering the threats to his safety. We consider these limitations in "Caring for yourself."

We evaluate the effects of impairments – the child's limitations – where we find them. This is the general principle that applies to evaluating all kinds of limitations. Once we have connected the child's limited activities to the domains involved in doing them, we ask whether the child has a medically determinable impairment(s) that affects those domains and accounts for the limitations.

VI-A6.* Where do we evaluate vision and hearing impairments that do not meet or medically equal a listed impairment? (12/00, Q28)

We evaluate vision and hearing impairments in whichever domain or domains they cause limitations. While it is impossible to generalize for all children, some children with these kinds of impairments may, for example, have delays in acquiring and using information or limitations in speaking and relating to others, or difficulty attending to activities. The point is that we

consider the effects of the impairment(s) when deciding if the impairment(s) functionally equals the listings.

B. Acquiring and using information

VI-B1. Can academic difficulties alone result in a rating of a marked or extreme limitation in "Acquiring and using information?"

Yes, if the academic difficulties are the result of a medically determinable impairment(s), and if the evidence includes clinical and lay descriptions of limitations in the child's ability to acquire and use information that are consistent with academic test scores (e.g., achievement tests) and academic records (e.g., teacher questionnaires, report cards).

Several factors may contribute to evaluating whether there is actually a marked or extreme limitation; e.g., whether the child has been identified for special education services and therefore receives extra help in learning, following directions, taking examinations, completing assignments, etc. A child's Individualized Education Program or an adolescent's Individualized Transition Plan will include considerable information about the kinds and level of assistance the child receives or the kinds of modifications made in his or her academic program (e.g., teaching methods) to enhance learning.

When a child is far behind in all subjects due to an MDI, there may well be other limitations. If it may be material to the determination (e.g., if we find one marked limitation, but there may be others), it may be necessary to do further development.

VI-B2. Do we consider receptive language under "Acquiring and using information" and expressive language and articulation under "Interacting and relating with others?"

We consider language and speech impairments in the same way we consider every other type of impairment under the revised functional equivalence rules. We consider the child's activities compared to that of children the same age who do not have impairments. We do not assign the language or speech impairments to specific domains, but as with all other impairments, consider a child's communication activities in whatever domain(s) is involved in those activities. For example, when using language to learn and think, the child is acquiring and using information; when using language to play with friends, the child is interacting and relating with others. In any language-related activity, however, a child is typically using both receptive and expressive language.

See Questions VI-D2 through VI-D5 in "Interacting and relating with others" for more guidance on assessing speech and language impairments.

C. Attending and completing tasks

VI-C1. How do "Attending and completing tasks" and "Caring for yourself" apply to children under age 3?

All of the new domains apply to children from birth to age 18 because all basic human abilities are present at birth and develop continuously throughout childhood.

"Attending and completing tasks" incorporates some aspects of the old areas of "Responsiveness to stimuli" which applied only to infants and "Concentration, persistence or pace" which didn't apply until age 3. The new domain addresses the very broad ability of attention more thoroughly, beginning at birth and continuing throughout childhood. For example:

- A newborn or young infant may demonstrate attention by alerting to stimuli coming from the environment, by gazing at human faces or moving objects, or by looking and listening in the direction of sound or human voices.

- A toddler may demonstrate attention by increasingly sustaining activity that interests the child, like repeatedly putting small toys in a container and then taking them out, listening to stories, and eventually by completion of some tasks (such as putting toys away) within age-appropriate norms.

"Caring for yourself" also applies to children under age 3 because the effort to become independent and competent in caring for one's physical and emotional wants and needs begins at birth and continues throughout the infant and toddler years. For example:

- A newborn or young infant may demonstrate independence by holding a bottle while feeding, or may use self-consoling behaviors such as sucking on a pacifier, thumb, or fingers when upset.

- A toddler may demonstrate independence through her increasing desire and attempts to do things for herself as in dressing herself, or may use a stuffed toy for company and consolation.

For more help, read the age-group descriptors for children under age 3:

- Attending/completing - DI 25225.035B.1. and 2. and § 416.926a(h)(2)
- Caring for yourself - DI 25225.050B.1. and 2. and § 416.926a(k)(2).

We included these descriptions to help adjudicators better understand how these domains apply to children under age 3 and, when necessary, to help pose questions to the parent, caregiver or physician to obtain the kind of information we need to evaluate these abilities.

See also Question VI-F1 for more discussion about the domain "Caring for yourself."

VI-C2. Is "Attending and completing tasks" about completing age-appropriate tasks or completing tasks in an age-appropriate manner?

The domain of "Attending and completing tasks" concerns the ability to attend and complete activities or tasks in an age-appropriate manner. The ability to attend is observable at birth and develops throughout childhood. The age group descriptors trace how this ability develops from birth to illustrate how it matures. For example, while a 4-year-old child might be expected to attend to an activity for ten minutes, a 14-year-old might be expected to attend to an activity for 40 minutes.

VI-C3. If a child has juvenile rheumatoid arthritis and has marked limitations in "Moving about and manipulating objects," can the child's slow handwriting also count as a marked limitation in "Attending and completing tasks?"

The "Attending and completing tasks" domain covers the psychological aspects of task completion – in other words, the mental pace that a child can maintain to complete the task. However, we evaluate the child's physical ability to complete the task in the domain "Moving about and manipulating objects" such as the child's ability to get dressed within a time frame appropriate for the child's age. See DI 25225.035 and (§ 416.926a(h) for the regulatory description of "Attending and completing tasks" as well as the discussion in Question VI-C4 below.

VI-C4.* What is the difference between the factor "How well [a child] can initiate, sustain and complete activities" and the domain "Attending and completing tasks"? (12/00, Q31)

We consider what the **factors** tell us about a child's functioning across all settings and activities. So the factor regarding the ability to "initiate, sustain and complete activities" (DI 25210.020; § 416.924a(b)(5)) addresses the issue of **independence** in functioning throughout sequential evaluation and in all domains, while the domain "Attending and completing tasks" (DI 25225.035; § 416.926a(h)) addresses only the child's specific ability to attend, focus on a specific task, ignore distractions and follow through on activities.

The factor addresses the extent to which a child can begin, carry out and finish activities **without needing extra help**. The child may receive help in a number of ways: personal service from another person; special equipment, devices, or medications; adaptations (such as special appliances); and structured or supportive settings, including the amount of help a child needs to remain in a regular setting.

The domain assesses how well a child focuses and maintains attention. This is manifest in how effective the child is in beginning an activity, filtering distractions while engaged in the activity, focusing long enough to finish it, working at a pace appropriate to the task, and changing focus once the activity is done.

How independently the child can "initiate, sustain, and complete activities" is considered in every domain. Therefore, when evaluating "Attending and completing tasks," we also consider

how independently the child functions in that domain. For example, a child in special education may be described as "pays attention well with frequent prompting." The need for prompting suggests the child is not paying attention with the independence that a child without an impairment would be expected to demonstrate. So despite the appearance of a minor limitation, this child is actually not functioning well and may have a marked limitation in attending and completing.

D. Interacting and relating with others

VI-D1. Assume a child has a medically determinable personality disorder that is manifested by limitations in "Interacting and relating with others." The child demonstrates behavior that is destructive to others, such as parents, teachers, bus drivers and coaches. Can a child qualify under the functional equivalence rules if there are no other relevant facts or circumstances?

Yes. A child may qualify if his or her activities indicate that there is an "extreme" limitation in "Interacting and relating with others." However, a statement that a child is "destructive to others" tells us very little about the nature of the child's activities in this domain so we need to probe further. We want to know such things as: what does "destructive" mean? how often does the activity occur? where does the activity occur? Although any child who is "destructive to others" because of an impairment will likely have some limitation in this domain, the severity of that limitation will depend on the nature, extent, frequency and intensity of such problems.

In assessing the severity of the limitation, we also need to consider the "factors" that apply to the evaluation of functioning at all steps of sequential evaluation, like the need for extra structure and support. For example, a somewhat aggressive 6-year-old who could be managed on the bus with the use of a seat belt would be limited, but if that were the only limitation the child had, we would probably not rate the domain even as "marked." The need for the seat belt indicates some lack of independence compared to other children the same age without impairments, but the amount and type of extra structure needed is not that great. But an aggressive child the same age who needs a seat belt, medications and a personal aide on the bus would probably be very seriously limited and could have an "extreme" limitation. Of course, we would need to consider how the child functions at home, at school and in the community, not just on the school bus.

VI-D2. The regulations incorporate language activities as part of "Interacting and relating with others." Please comment on why language is part of interacting and relating.

Communication is an essential part of interacting and relating with others, and language is essential to communication. The regulations at §416.926a(i) (see also DI 25225.040) state that we consider how a child **develops and uses** the language of his or her community, and they incorporate several language activities as exemplars. Children must develop the ability to communicate clearly and grammatically. But, when interacting with others, they must also learn to appropriately use the language they have developed. Language **use**, or **pragmatics**, is the component of language competence that is social in nature and assumes interaction with others.

“Pragmatics” is about how well a child conveys a range of communicative intents or purposes (to a variety of listeners in a range of environments) while also considering the listener. True, a child must decide *what message* he/she wants to convey, and then formulate it according to specific rules. But the child also must take into account a whole range of factors that influence both the expression of that message *and* the listener’s comprehension of it. These factors include the rules of conversation, like turntaking, as well as the listener’s perspective, the speaker/listener relationship, and “nonverbals” such as eye contact, gestures, and facial expressions. For example, a boy who requests something of a teacher in the same way he would a sibling may get his point across – but he may be seen as disrespectful because he failed to respect the relationship between himself and the adult. Likewise, classmates will not take kindly to a child who is unable to interpret nonverbal communication such as facial expressions, to recognize sarcasm, or to understand popular slang.

Even before speaking their first words, infants communicate through gestures and vocalizations for several purposes (for example, requesting objects and protesting). With the acquisition of first words, the repertoire of purposes for using language expands (to include, for example, requesting information). As their vocabularies grow and their utterances become longer and more complex, children continue to expand their range of communicative intents. By the time a typically developing child reaches school age, he or she demonstrates a wide range of purposes for language use. Through the school years, children learn to use language for purposes unique to the classroom (e.g., reciting, retelling), and participate in new verbal interactions defined by their peer group’s culture. In the later years, broadened social experiences and emerging independence result in more adult-like styles of communication, which are further refined by continued educational experiences. A school age child who uses language for only a few communicative purposes (e.g., requesting and protesting) will be very limited in interacting with others.

It’s important to note that a speaker’s cultural background also influences his or her pragmatic behaviors. For example, teachers in many North American cultures expect children to maintain eye contact with them during conversations. Children from Asian backgrounds, however, are often trained to show respect to authority figures by not establishing eye contact with them.

VI-D3. Does a “marked” or “extreme” limitation in speech under the tables in SSR 98-1p lead to a “marked” or “extreme” limitation in “Interacting and relating with others” even if all other aspects of that domain are less than marked?

Yes. This is because communicating is a major activity in “Interacting and relating with others” and communicating involves the activity of speaking intelligibly. The definitions of “marked” and “extreme” limitations in DI 25225.020 B.1. and C.1. and § 416.926a(e) explain that a child’s daily functioning may be seriously (or very seriously) limited when an impairment limits only one activity.

Of course we should evaluate limitations resulting from the child’s speech impairment in any and all domains affected. Remember too that a child may have a “marked” or “extreme” limitation in “Interacting and relating with others” or another domain even if his or her speech impairment doesn’t meet the criteria in the SSR 98-1p tables.

See also Question II-3 for other guidance about using SSR 98-1p for cognitive and speech limitations that medically equal listing 2.09.

VI-D4. What about the child who has a marked limitation in speech, but has normal pragmatic language abilities? Is "Interacting and relating" still rated as "marked?"

Yes. Many of us have attempted to converse with someone whose speech is largely unintelligible due to a stroke, traumatic brain injury, or tracheotomy, even though his or her pragmatic language abilities may be spared. The conversation is frequently quite one-sided because the person can communicate very little information via speech, although polite behaviors and "nonverbals" are demonstrated. Essentially, his or her ability to interact (which, by definition, requires active participation by two people) is significantly limited.

The same principle applies to the child who has intact pragmatic abilities but a marked limitation in speech due to difficulties with one or more aspects of speech. The child may be very friendly and considerate of others, get along well with them, and use "nonverbals" skillfully. But if the child cannot use speech appropriately to interact with others, the nature and amount of information he or she can share with them will be significantly limited, thus affecting the quality (the breadth and depth) of interactions and relationships. See Question VI-D2 for more discussion about "pragmatic" language.

VI-D5. Under "Interacting and relating with others," what do we mean by "the language of your community" as it pertains to a child who is non-English-speaking or bilingual?

We mean we consider a child's use of his or her primary language in evaluating whether the child has language-related limitations.

We need to measure a child's language ability by the appropriate standard – i.e., by how well he or she uses the language he or she knows best – to avoid incorrectly identifying as "impaired" those children who are simply learning a second language or who demonstrate dialectal differences. A child whose first language is not English may have difficulty interacting with others in English. This does not mean that the child has language impairment. It is important to distinguish between the phenomena of normal second language acquisition and manifestations of true language impairments. The child who performs poorly when communicating in English but performs well in his or her native language does not have a language impairment.

E. Moving about and manipulating objects

VI-E1. Does "Moving about and manipulating objects" cover the effects of mental impairments?

Yes, if the mental impairment affects a child's physical ability to move his or her body from one place to another, to change position or posture, or to manipulate objects, large and small, as may occur in some somatoform disorders. There are medications which affect how a movement is

performed and can cause such things as tremors, tardive dyskinesia or a Parkinson-like syndrome. If these effects persist over time and despite dosage changes or because such dosage changes are not possible, they should be considered in this domain, "Moving about and manipulating objects."

Medications can also affect how readily or frequently a person can perform a movement. These effects, such as fatigue or drowsiness, etc., should be considered under the "Health and physical well-being" domain.

Medications that affect memory or otherwise interfere with mental processes may have their effects in other domains, such as "Acquiring and using information" or "Attending and completing tasks." The specifics of the medical record should allow the effects to be assigned appropriately.

F. Caring for yourself

VI-F1. What is the scope of "Caring for yourself?"

"Caring for yourself" is about the ability to become increasingly independent and responsible for taking care of both physical and emotional wants and needs. The key words in this statement are "independent" and "responsible." In "Caring for yourself," we are not looking at the child's **physical** ability to care for personal needs – we consider that ability under "Moving about & manipulating objects" and possibly "Health & physical well-being." And, although the new domain addresses personal needs such as feeding, dressing, hygiene, and health, it is not only about these familiar "self-care" issues. Rather, this new domain is about a different but very important point: Underlying all aspects of a child's functioning is the developing ability to be independent and responsible in caring for him- or herself.

For a child to care for him- or herself, he or she must develop not only the readily observable self-care skills, but also some less observable skills, like those needed for coping with stress, change, anger, disappointment, or fear. These skills are often referred to as "self-regulation," and limitations in these skills may be seen in children with emotional impairments such as depression and anxiety disorders. For example, when faced with a stressful situation or conflict, a child may use denial or escape rather than problem-solving skills to deal with his stress, and this pattern may show up in the child's activities at home and at school.

Limitations in self-regulation may also result in failure to follow safety rules and precautions, in risk-taking behaviors, and in self-injurious behaviors. When considering a child's ability to care for him- or herself, we must not overlook such behaviors. For example, in a recent case involving a 15-year-old girl, adjudicators found no limitation in Caring for yourself because the girl had adequate personal grooming and hygiene. The child's treating psychiatrist, however, reported consistent suicidal ideation with several suicide gestures in the previous few months and a history of self-mutilation (e.g., carving the word "crazy" in her arm with a knife), as well as running away from home. These limitations should have been considered, and their severity rated, in "Caring for yourself."

We're basically talking about how a child relates to him- or herself, so this domain means just that - taking care of yourself. It does not involve the child's physical abilities or the ability to relate to other people, but its scope is much broader than personal grooming and hygiene.
See also Question VI-C1 for a discussion of the "Caring for yourself" domain for children under age 3.

G. Health and physical well-being

VI-G1.* Why is there a domain just for "Health and physical well-being"? (12/00, Q27)

The "Health and physical well-being" domain covers the cumulative physical effects of physical and mental impairments and their associated treatment or therapies that aren't addressed in the "Moving about and manipulating objects" domain (DI 25225.055; § 416.926a(l)). We created it to respond to a longstanding concern of the public and adjudicators that we should provide more guidance addressing the problems of children who are physically ill or who manifest physical effects of mental impairments. Examples of who to evaluate in this domain include: The child whose activities are restricted because asthma causes him or her to fatigue more easily than other children the same age who don't have impairments; the child who doesn't participate in activities because clinical depression makes him or her too tired; and the child whose activities are limited because he or she is taking medication that produces nausea.

We believe that the new domain for addressing the cumulative physical effects of physical or mental impairments provides a clearer way to fold two previous functional equivalence methods (episodic impairments and treatment or medication effects) into the revised functional equivalence framework. It should also make it easier to use the principles underlying the prior methods and ensure thorough and careful evaluation of the physical effects of a child's impairment(s).

See also Question VII-6 for discussion of rating severity in this domain.

VI-G2.* What is the difference between assessing the effects of chronic illness and treatment throughout the sequential evaluation process and assessing a child's "Health and physical well-being?" (12/00, Q32)

There is a principal difference between the factors, "Impact of chronic illness..." and "Effects of treatment," and the "Health and physical well-being" domain. The factors address any kind of effect that a child's health problems (physical or mental) may have upon his or her functioning across all activities and settings, and throughout sequential evaluation.

In contrast, the domain addresses only the cumulative physical effects of physical or mental impairments and of their associated treatments or therapies on a child's functioning that we did not consider under the domain, "Moving about and manipulating objects." This means that the physical effects of a physical or mental impairment are to be considered in only two domains: "Moving about and manipulating objects" or "Health and physical well-being."

The factors of chronic illness and treatment effects (DI 25210.035 and DI 25210.040; §§ 416.924a(b)(8) and 416.924a(b)(9)) recognize that a child's health problems (physical or mental) can have various kinds of effects that may influence functioning in many activities and settings. For example, pain associated with chronic illness may impair a child's attention and concentration (a psychological effect) and may thereby limit his or her ability in "Attending and completing tasks." The child's response to the social stigma associated with some visible physical anomaly (e.g., repaired cleft lip, missing limbs, abnormal gait, dysfluent speech, use of adaptive equipment) – a social effect – may interfere with the child's ability to relate satisfactorily to peers. These effects, associated with chronic conditions, are considered with respect to all the pertinent activities and associated abilities. See also Question VI-E1 for a discussion of medication effects.

The "Health and physical well-being" domain (DI 25225.055; § 416.926a(l)) addresses only the physical effects of a child's physical or mental impairment(s) so it provides a more focused and intensive assessment of a child's physical limitations.

See also Question VII-6 for discussion about rating severity in this domain.

VI-G3. What is the definition of "exacerbation" and how do we know when an episode begins or ends?

It means the same thing that it does in a number of listings and we determine the beginning and ending in the same way as under the listings.

An exacerbation is an increase in the severity of a disease or its symptoms. A chronic disease may have stable signs and symptoms that increase at the start of an exacerbation and then decrease again as the exacerbation wanes. Or the individual with an underlying disease may feel well much of the time and periodically have an episode or exacerbation of illness. Any significant exacerbation should be documented in the medical record. There must also be documentation of the resultant limitation in functioning.

The length of the exacerbation is based on the change in signs and symptoms and the functional limitation. The main consideration in determining the length of an exacerbation, for purposes of this domain, is the duration of the increase in functional limitation. Signs and symptoms may initially change without a significant change in function. Likewise, as the exacerbation is resolving, signs and symptoms may begin to abate before there is an improvement in function.

Also, the length of an exacerbation is not simply the length of treatment, since treatment is usually continued beyond the time of resolution of symptoms. The record must be carefully reviewed for evidence from all sources as to the beginning and end of a change in function in order to assess the length of an exacerbation. Any side effects of treatment must, of course, be considered.

VI-G4. How do we distinguish "Moving about and manipulating objects" and "Health and physical well-being"?

The "Moving about and manipulating objects" domain covers how well a child can handle objects and move his or her own body. It is basically the old "motor" domain. The new domain for "Health and physical well-being" is intended to cover all of the other physical effects not already considered under "Moving about and manipulating objects."

See also Questions VI-EI, VI-GI, and VI-G2 for more information about the relationship between the two domains..

VI-G5. Do we include episodes of ear infection, tonsillitis and leg pain in "Health and physical well-being"?

Possibly, but in most cases these brief illnesses will not count. We cannot consider episodes of illness that do not meet the duration requirement in determining disability. The fact that most of us are sick a few times a year with one thing or another is not a basis for a finding of disability. However, there are impairments such as sickle cell disease or immune deficiency diseases that increase a person's susceptibility to infection or other disorders. Those episodes of illness that are considered associated with the underlying impairment certainly count in this domain.

VI-G6. Does "Health and physical well-being" cover the effects of a mental impairment?

Yes, if the impairment causes physical limitations that are not covered by "Moving about and manipulating objects." So, for example, we rate the child's side effects like dizziness from psychotropic medications here. Because this domain is about physical effects, we would not find a limitation here based simply on the fact that the child uses psychotropic medications or has had psychiatric hospitalizations. But keep in mind that medications and hospitalizations, which are a structured setting, are factors that must be considered throughout the process. See DI 25210.040 and § 416.924a(a).

VI-G7. Should we rate asthma cases in "Health and physical well-being"?

Under the final rules, we consider what a child can or cannot do and what activities are limited in all domains compared to other children the same age who do not have impairments. We do not restrict consideration of particular impairments to particular domains.

However, the limitations typically imposed by asthma due to shortness of breath, fatigue, and frequent illness, would be evaluated under this domain. Our analysis depends on the specifics of the case: How many episodic events has the child experienced? How severe were they? Remember also that the asthma listing (103.03B) considers the frequency of episodes and hospitalizations so the child may qualify without having to go to the functional equivalence step of the sequential evaluation process.

VI - G8. The regulations describing the domain of "Health and physical well-being" list "psychomotor retardation" as a "physical effect" that should be considered under this domain. What does this mean?

Most pediatricians and developmental specialists use the term psychomotor retardation to describe children with some combination of cognitive, communicative and motor limitations, while psychiatrists and psychologists use it in a more restricted sense, to mean the motor effects of psychiatric impairments, such as the slow or limited movement that may be seen in a seriously depressed individual. In the final regulations, we intended the latter meaning (motor effects of psychiatric impairments), which is the same meaning it has in our mental disorders listings.

Because different specialists use the term to mean different things, it is important to read carefully any evidence that uses the term to understand how it is used.

Topic VII: Rating "Marked" and "Extreme" Limitations

VII-1.* Why are the words "seriously" and "very seriously" used in the general definitions of "marked" and "extreme"? (12/00, Q34)

VII-2.* If a child has a major problem with one activity in a domain, does this mean the child has a "marked" limitation in that domain? (12/00, Q25)

VII-3.* When a child is limited in more than one activity in the same domain, can we rate the domain as "marked"? (12/00, Q26)

VII-4. How do we convert considerations about a child's functioning to ratings of severity? If we can use all the other non-standard sources of information about functioning, do we still need to have all the previous "program standard evidence" like particular IQ tests or speech or language tests in order to make the assessment?

VII-5. If a child has marked limitations in both receptive and expressive language, will those limitations functionally equal a listing?

VII-6.* Why does "Health and physical well-being" have an alternative way to rate severity? (12/00, Q35)

VII-7. How do we judge what is "substantially in excess of a "marked" limitation to find an "extreme" limitation in "Health and physical well-being?"

VII-8. Will a child who has multiple episodes of unrelated illness that lasted 2 weeks each have a marked limitation in "Health and physical well-being?"

VII-9. Do the new definitions of "marked" and "extreme" for functional equivalence change any specific listing criteria that also include frequency of attacks, like asthma?

Answers

VII-1.* Why are the words "seriously" and "very seriously" used in the general definitions of "marked" and "extreme"? (12/00, Q34)

"Seriously interferes" is the most general description of a "marked" limitation. We cannot give a cookbook definition because of the wide variability of case facts, but that phrase should be read in conjunction with all the other definitions of "marked":

- More than moderate but less than extreme
- The equivalent of functioning we would expect on standardized testing with scores that are at least 2 but less than 3 standard deviations (SD) below the mean
- At any age, a valid score that is at least two SD below the mean but less than three, on a comprehensive standardized test and functioning is consistent with that score.
- Under age 3, when we do not have standard scores from standardized testing, functioning at more than one-half but not more than two-thirds of chronological age
- For the "Health and physical well-being" domain, frequent exacerbations that result in documented symptoms or signs.

Similarly, "very seriously interferes" is the broadest of the descriptions of an "extreme" limitation, but do not read that description in isolation. Consider it in light of all the definitions:

- More than marked
- The equivalent of functioning we would expect on standardized testing with scores that are at least 3 standard deviations (SD) below the mean
- At any age, a valid score that is at least 3 SD below the mean, on a comprehensive standardized test and functioning is consistent with that score.
- Under age 3, when we do not have standard scores from standardized testing, functioning at one-half or less of chronological age
- For the "Health and physical well-being" domain, frequent exacerbations that result in documented symptoms or signs substantially in excess of the requirements for a marked limitation.

See DI 25225.020; § 416.926a(e).

VII-2.* If a child has a major problem with one activity in a domain, does this mean the child has a "marked" limitation in that domain? (12/00, Q25)

Not necessarily. In the regulations, each domain description states that the examples of typical functioning are not all-inclusive and the examples of limitations are not necessarily "marked" or "extreme." On the other hand, it has always been our policy that not every function within a broad domain must be affected for there to be a "marked" or "extreme" limitation.

Many of the examples of typical functioning describe relatively minor activities like "coloring." If a preschooler has a major problem in one of these minor activities and no other limitations in the same domain, we would not find a marked limitation based on that one problem. But we need to be careful, for two reasons:

- First, it is unlikely that a child would have such a circumscribed limitation as a major problem with coloring and no other problems (although it is possible, e.g., due to color-blindness). Before drawing any conclusion in a case with such an isolated finding, consider whether the child's problem in that one activity is just one example of more pervasive limitations and whether we have enough information to determine the child's overall functioning.
- Second, by no means are all the typical activities as minor as "coloring." For example, one of the activities described for toddlers under acquiring and using information is to "form concepts . . . ." A problem with forming concepts, if sufficiently severe, might very well support a marked or extreme limitation by itself.

But also remember that even children without impairments do not necessarily participate in all the sorts of activities described, and this is not necessarily a sign of a limitation. For example, under "Interacting and relating with others" we included extracurricular activities and sports as typical activities of children without impairments, but some children without impairments do not choose to participate in these activities. Not participating in one of the "typical" activities signals

a limitation only if a medically determinable impairment(s) is the reason the child does not or cannot participate.

The examples of limitations do, of course, describe limited functioning, but the conclusion whether the child has a "marked" or "extreme" limitation in a domain requires consideration of all the relevant evidence.

See also Question VII-3 for a discussion about how to evaluate a child who is limited in more than one activity in the same domain.

VII-3.* When a child is limited in more than one activity in the same domain, can we rate the domain as "marked"? (12/00, Q26)

Yes, depending on the nature of the activities and severity of the limitations. The childhood SSI regulations specify that there may be marked limitation "when your impairment(s) limits only one activity or when the interactive and cumulative effects of your impairment(s) limits several activities" (DI 25225.020B1; § 416.926a(e)(2)). This is only a clarification of child rules that date back to 1991, which provided that "marked limitation may arise when several activities or functions are limited or even when only one is limited as long as the degree of limitation is such as to interfere seriously with the child's functioning." (See, e.g., § 416.926a(c)(3)(C) of the interim final rules.) The adult mental disorders listings have included essentially the same definition since 1985, as have the childhood mental disorders listings since 1990.

There is no rule that says a certain number of limited activities equal a marked (or extreme) limitation. The issue is whether the limitations in a domain seriously (or very seriously) interfere with the child's functioning. Therefore, it is important to consider whether the interactive and cumulative effects result in a marked or extreme limitation in each domain.

VII-4. How do we convert considerations about a child's functioning to ratings of severity? If we can use all the other non-standard sources of information about functioning, do we still need to have all the previous "program standard evidence" like particular IQ or speech or language tests to make the assessment?

We must "convert" considerations about the child's functioning to ratings of severity in the same way we did previously - determine whether the child's functional limitations resulting from his or her medically determinable impairment(s) are "serious" or "very serious." (See the definitions of "marked" and "extreme" limitations in DI 25225.020. and 416.926a(e))

It is unclear what is meant by "non-standard sources of information." We contact the same medical and nonmedical sources for evidence when evaluating childhood claims that we started explicitly requiring in 1990 and use the same kinds of evidence from them. The provisions of the final rules that address functional equivalence do not negate consideration of formal test evidence (e.g., IQ, language) where applicable, although the rules make it clear that test scores are not considered in isolation. The determination or decision must be based on all the information in the case record, including any formal test or assessment data, and any clinical and lay descriptive information obtained about a child's daily activities.

VII-5. If a child has marked limitations in both receptive and expressive language, will those limitations functionally equal a listing?

It is not appropriate to talk about "marked" limitations in receptive and expressive language when we assess functional equivalence. Language is not a domain and neither are the receptive and expressive parts of language. We must evaluate the child's activities and the functional effects of receptive/expressive language impairments and rate those effects in all appropriate domains.

See also Question VI-B2 for a discussion of how to consider receptive and expressive language and articulation.

VII-6.* Why does "Health and physical well-being" have an alternative way to rate severity? (12/00, Q35)

We added alternative rating criteria because of the unique character of this domain, which is less about activities than the other domains and more about such things as frequent illness or a need for frequent, intrusive treatment. There is, however, an underlying presumption that these sorts of problems result in limitations in a child's activities, especially when viewed longitudinally.

We adopted the definition of "marked," which describes the frequency of effects that demonstrate the required level of severity, from existing rules that are analogous to this domain. Similar criteria are found in the Immune System section of the adult listings, 14.00D8, for the episodic physical manifestations of HIV, and in the adult mental impairment listings, 12.00D4, for episodes of decompensation (65 FR 50746, 50777). We also defined an "extreme limitation," consistent with the severity standard, but we also indicated that there is a good chance that impairments rated "extreme" in this domain would meet or medically equal a listing.

VII-7. How do we judge what is "substantially in excess of" a "marked" limitation to find an "extreme" limitation in "Health and physical well-being"?

This is a judgment call. We must find that the child's impairment is of listing-level severity. This is the main reason that we indicated that a child whose functional limitations met this definition of "extreme" in this domain would probably have an impairment that met or medically equaled a listing. And remember that there are other definitions of "extreme" - see DI 25225.020C. and § 416.926a(e)(3) as discussed in Question VII-1.

VII-8. Will a child who has multiple episodes of unrelated illness that lasted 2 weeks each have a marked limitation in "Health and physical well-being?"

Remember that we consider only impairments that meet the duration requirement, but we consider the combined effects of all such impairments. If the child has 3 separate impairments, each of which meets the duration requirement and they each had an exacerbation that caused functional limitations for 2 weeks, the combined effect could, depending on the severity of the

functional limitation associated with each episode, result in a "marked" limitation in "Health and physical well-being."

See also Question VI-G5 concerning impairments that may not meet the duration requirement.

VII-9. Do the new definitions of "marked" and "extreme" for functional equivalence change any specific listing criteria that also include frequency of attacks, like asthma?

No. § 416.925(b)(2) of the regulations (DI 25220.010B.1.b.) continues to provide that, when we decide whether an impairment(s) meets the requirements for any listed impairment, we will decide that the impairment(s) is of listing-level severity even if it does not result in marked limitation in two broad areas of functioning, or extreme limitation in one, if the listing that we apply does not require such limitations. This principle is true for medical equivalence too.

For example, listing 103.03B is still met with attacks in spite of prescribed treatment and requiring physician intervention, occurring at least once every 2 months or at least six times a year. The definition in 416.926a(e)(2)(iv) is for functional equivalence decisions and does not supersede the criteria in any of the listings.

Topic VIII: Processing Continuing Disability Reviews (CDRs)

VIII-1. How do we do CDRs?
VIII-2. If there is no medical improvement (MI) at CDR, must we describe all findings on the SSA-538 or can we just complete the first page?
VIII-3. A CDR reconsideration file in the Disability Hearing Office (DHO) ordinarily includes an advisory SSA-538 from the DDS. If the advisory SSA-538 is the old version, does the DHO need to request a new one?
VIII-4. What form will DHOs use for childhood CDR cases?
VIII-5.* Explain the "show treatment" provision. How do we do this? (1997)

Answers

VIII-1. How do we do CDRs?

Follow the existing instructions in DI 28005.020 - DI 28005.030 and § 416.994a. For cases in which functional equivalence must be considered at step 2, follow EM-01074 (04/23/01). The EM explains that, for every case in which medical improvement is found at step 1, and at step 2 the CPD impairment(s) does not currently meet or medically equal the CPD listing, we use the final childhood rules to decide whether the CPD impairment(s) functionally equals the listings - i.e., causes marked limitations in 2 domains in the current rules or extreme limitation in 1 domain.

Note that in a few places the POMS instructions have not yet been updated to replace the term "functionally equals the severity of **a listed impairment**" and similar language with the appropriate language from the final regulations: "functionally equals **the listings**"

VIII-2. If there is no medical improvement (MI) at CDR, must we describe all findings on the SSA-538 or can we just complete the first page?

The decision must be sufficiently explained in Section III that an independent reviewer will be able to understand how the adjudicator decided that there is no MI.

VIII-3. A CDR reconsideration file in the Disability Hearing Unit ordinarily includes an advisory SSA-538 from a DDS consultant. If the advisory SSA-538 is the old version, does the Disability Hearing Officer (DHO) need to request a new one?

Not necessarily. The advisory SSA-538 is just that - "advisory." The DHO is responsible for evaluating the claim and making the determination under the final rules. DHOs consider these forms to be medical opinion evidence in the same way that ALJs and the Appeals Council do.

The opinions provided on a prior version of an SSA-538 may still be useful. For example, there may be an explanation of the child's medical conditions or an opinion about how conflicting evidence should be resolved. However, if the DHO believes that it is helpful to ask for a new advisory SSA-538 based on the final rules, he or she may do so.

VIII-4. What form will DHOs use for childhood CDR cases?

We are working on a new form specifically for childhood CDRs that will be the SSA-1209. In the meantime, follow the current instructions to incorporate the elements of the SSA-538 when completing the SSA-1207 (Disability Hearing Officer's Decision) (see DI 33015.020B, Note). We will also revise the SSA-1204(DC)-BK (Disability Hearing Officer's Report of Disability Hearing) to correspond to the final childhood rules.

VIII-5.* Explain the "show treatment" provision. How do we do this? (1997)

The "show treatment" provision is explained in DI 28005.031 and § 416.994a(i). See DI 28005.031 for details about the procedure to follow if the current representative payee is not ensuring that the child obtains treatment that is both "medically necessary" and "available."

See also Question IV-9 for discussion of the "failure to follow prescribed treatment" provision.

Topic IX: Completing Revised Form SSA-538 and Other Children's Forms

IX-1.* Now that the revised SSA-538 is two pages longer than the old version, how long will it take us to complete it? (12/00, Q39)
IX-2.* Why are we required to provide more explanations on the revised SSA-538? (12/00, Q36)
IX-3. Why is so much policy information included on the SSA-538?
IX-4.* Can the SSA-538 serve as a formal rationale in lieu of the SSA-4268? (1997)
IX-5. What is the appropriate way to delete or revise material on the SSA-538?
IX-6.* Can a disability examiner assist in the completion of the SSA-538?
IX-7. How should we complete the SSA-538 when a child has multiple problems, but they are not all considered "severe" impairments?
IX-8.* May we reference the initial SSA-538 on the reconsideration SSA-538 when no new evidence is presented? (1997)
IX-9.* Why are the disability hearing officers, ALJs and the Appeals Council not required to complete the SSA-538? (1997)
IX-10.*If a child attains age 18 after filing an application but prior to a determination, do we complete the SSA-538? (1997)
IX-11.*Where do we file the SSA-538 in the 6-part claims folder? (1997)
IX-12. Why was the "engaging in SGA" question added to the top of the SSA-538?
IX-13. Why does DI 25230.005A tell us to list both medically determinable impairments (MDIs) and any impairments recorded but *not* established as MDIs on the SSA-538?
IX-14. If the child qualifies under one of the Examples in the FE rules, do we still need to complete the back of the form?
IX-15. Do we still need to complete an SSA-538 for "failure to cooperate" determinations?
IX-16.*Why are consultants required to affirm that they considered "Factors" and "Evidence" when completing the SSA-538? (12/00, Q37)
IX-17.*Why does the SSA-538 now require a consultant to sign as having "overall responsibility" for the case findings? (1997)
IX-18. In a denial, when a physician has overall responsibility in a case involving a combination of both physical and mental impairments, does a psychologist or psychiatrist have to review the case and sign off on the SSA-538?
IX-19. If a child has a marked limitation in "Interacting and relating" because of a speech impairment alone, is the speech-language pathologist (SLP) allowed to rate the domain independently or does a psychologist make that call?
IX-20. What MCS Specialty Code should be used on the SSA-831 or SSA-832 if an SLP signs the SSA-538 as the consultant having overall responsibility?
IX-21. In Prototype States, can single decision-makers (SDMs) sign the SSA-538?
IX-22.*Why are we now required to write a narrative for each of the six domains? What if the child has no limitation in a domain? (12/00, Q38)
IX-23. Can we write a decision narrative or summary in Section III of the SSA-538 rather than individual domain narratives in Section II?
IX-24. When more than one consultant completes a single SSA-538, should each consultant initial his or her comments in each domain and in Section III?
IX-25. Is the agency going to revise the national age-specific function forms?
IX-26. Do we need to copy information from the Teacher Questionnaire onto the SSA-538 or can we just reference it?

Answers

IX-1.* Now that the revised SSA-538 is two pages longer than the old version, how long will it take us to complete it? (12/00, Q39)

The extra length of the form consists mostly of reminders, a more complete description of “marked” and “extreme” limitations, and more space for explanations that have always been required. We estimate it will take adjudicators an average of 25 minutes to complete the revised SSA-538. It may initially take somewhat longer while adjusting to the new format. Of course, it may take longer than that in some cases and less time in others, depending on the facts.

IX-2.*Why are we required to provide more explanations on the revised SSA-538? (12/00, Q36)

We are not required to provide any more information than before. The only change is where the information is provided. The revised SSA-538 has more spaces dedicated to explaining specific items (e.g., nonsevere impairment(s); the domains), but most of the explanations have always been required on the form. The only new explanation required on the SSA-538 is for Disposition 2, Medical Equals. Explanation for medical equals determinations has always been required somewhere in the file, but it made better sense to include that explanation on the SSA-538 with the other explanations.

IX-3. Why did is so much policy information included on the SSA-538?

We did this for two major reasons:

- First, it serves as a convenient reference because we know many adjudicators get childhood cases relatively infrequently.
- Second, it emphasizes the importance of the revised provisions in the final rules, such as the need to compare a child’s functioning to that of children the same age who do not have impairments.

IX-4.* Can the SSA-538 serve as a formal rationale in lieu of the SSA-4268? (1997)

Yes, per DI 25235.001. It may serve as a rationale if it contains all the elements required in a rationale, such as the claimant's allegations, the relevant evidence, and the weight attributed to the pertinent evidence. See the general guidelines in subchapters DI 26515, 27020 and 28090. If all the rationale elements are not on the SSA-538, they must be shown on form SSA-4268.

IX-5. What is the appropriate way to delete or revise material on the SSA-538?

If there are whiteout or other changes to information recorded on the SSA-538 and the changes are not initialed and dated, ALJs are not able to tell who made the changes and whether the form was altered after the MC or PC signed it. In those cases, they cannot consider the form.

Therefore, if any information on the SSA-538 is changed, (with whiteout or otherwise) the consultant or examiner who made the change must initial or sign and date the change. If it will not be evident who the individual is from the initials alone, the individual must also provide information (such as his or her title) so subsequent reviewers know who made the change. At the hearings and appeals levels of review, an SSA-538 that includes a properly initialed change must not be excluded from the evidence because of the change**.**

IX-6.* Can a disability examiner assist in the completion of the SSA-538? (1997)

Yes. See DI 25230.001B.4.

IX-7. How should we complete the SSA-538 when a child has multiple problems, but they are not all considered "severe" impairments?

See Questions IV-11 and IV-12 on how we consider the interactive and cumulative effects of impairments that include combinations of "severe" and "not severe" impairments and combinations of "not severe" impairments.

IX-8.* May we reference the initial SSA-538 on the reconsideration SSA-538 when there is no new evidence presented? (1997)

Yes. DI 27020.010 provides all of the conditions that must be satisfied when a previous denial determination may be affirmed. If all those conditions are met, the reconsideration SSA-538 can reference the initial SSA-538 with a remark in Section III like "The SSA-538 dated______ is affirmed as written." However, the SSA-538 still must be properly signed. This procedure is not new. It was provided in response to an October 1998 WELF question.

IX-9.* Why are the disability hearing officers (DHOs), ALJs and the Appeals Council not required to complete the SSA-538? (1997)

They are not required to complete the form because they must write detailed rationales that provide all of the information summarized on the form. However, if they wish, they may use the form as a guide to ensure that they have considered all the steps in sequential evaluation.

IX-10.*If a child attains age 18 after filing an application but prior to a determination, do we complete the SSA-538? (1997)

Yes, for the period up to attainment of age 18. For the period beginning with the day of attainment of age 18, complete any appropriate forms for an adult claim, including as necessary the psychiatric review technique form (PRTF) and physical and mental residual functional capacity (RFC) assessment forms. See DI 25201.010; § 416.924(f).

IX-11.*Where do we file the SSA-538 in the 6-part claims folder? (1997)

It is considered medical evidence and is filed in the yellow section in the back of the folder

IX-12. Why was the "engaging in SGA" question added to the top of the SSA-538?

We added this in response to requests from the participants in the final rules pilot. Although the field office (not the DDS) makes the determination whether the child is engaging in SGA, it is helpful to include the SGA finding on the SSA-538 because it is part of the sequential evaluation process for children. If the SSA-538 does not show this information somewhere, the form cannot serve as the determination rationale (see DI 25235.001).

IX-13. Why does DI 25230.005A tell us to list both medically determinable impairments (MDIs) and any impairments recorded but *not* established as MDIs on the SSA-538?

The purpose is to list both MDIs and alleged impairments that we could not establish as MDIs so that subsequent reviewers can see at a glance the impairments and alleged impairments that should be addressed in the body of the SSA-538. As noted in DI 25230.005A, it is critical to distinguish between MDIs and alleged impairments **not** established.

IX-14. If the child qualifies under one of the Examples in the FE rules, do we still need to complete the back of the form?

Yes. The Examples appear in DI 25230.060 and § 416.926a(m). After we check disposition #4 on page 1 and fill in the example number, explain in Section III on page 6 why the example applies. We do not need to assess the domains if the child's impairment(s) satisfies the criteria in one of the examples.

IX-15. Do we still need to complete an SSA-538 for "failure to cooperate" determinations?

Yes. After we check disposition #7 on page 1 and fill in the disposition, we must explain what efforts were made to gain cooperation in Section III on page 6. Remember that in childhood cases we must follow DI 25205.015, which requires special efforts to identify and contact an adult or agency responsible for the child's care before denying on the basis of "failure to cooperate."

IX-16.*Why are consultants required to affirm that they considered "Factors" and "Evidence" when completing the SSA-538? (12/00, Q37)

The affirmation check-block and the related text on page 2 of the SSA-538 are reminders of the factors and evidence that must be considered when evaluating a child's functioning throughout the sequential evaluation process. We added this text because the "Factors" material was significantly reorganized and expanded in the final rules, and we included the check-block as a memory jogger to emphasize the importance of both the factors and all relevant evidence.

IX-17.*Why does the SSA-538 now require a consultant to sign as having "overall responsibility" for the case findings? (1997)

The "overall responsibility" provision has been in regulations and the POMS since February 1997. Current references are § 416.924(g) (unchanged from the interim final rules) and

DI 25201.015 (DI 25201.020 previously). Consultants have always signed the SSA-538 and by signing attested to their evaluation of the child's impairments and the medical disposition of the case. The only difference now is that the words "overall responsibility" appear on the form.

IX-18. In a denial, when a physician has overall responsibility in a case involving a combination of both physical and mental impairments, does a psychologist or psychiatrist have to review the case and sign off on the SSA-538?

See DI 25201.020 (§ 416.903(e) and § 416.1015(d)) for the requirement that we must make reasonable efforts to ensure that a qualified psychiatrist or psychologist has evaluated any mental impairment in an unfavorable initial determination. If a child has both physical and mental impairments and a psychologist reviews the case to evaluate the effect of the mental impairment, he or she must sign and date in one of the signature boxes under the first box, which is designated for the consultant with overall responsibility. A psychiatrist may sign as the consultant with overall responsibility for the findings in a denial in which there are both physical and mental impairments because a psychiatrist is a physician.

IX-19. If a child has a marked limitation in "Interacting and relating" because of a speech impairment alone, is the speech-language pathologist (SLP) allowed to rate the domain independently or does a psychologist make that call?

As with all medical and psychological consultants, the SLP can and should rate limitations resulting from impairments in his or her specialty in whatever domain(s) is affected.

Furthermore, if the speech or language impairment is the only impairment, the SLP can sign as the consultant with overall responsibility, whether the determination is favorable or unfavorable. Likewise, if the speech or language impairment is not the only impairment, but is sufficient by itself for an allowance, then the SLP can sign as the consultant having overall responsibility. The psychologist's signature is not required. See DI 25230.005D.2 for a complete discussion of who can sign as the consultant with overall responsibility.

IX-20. What MCS Specialty Code should be used on the SSA- 831 or SSA-832 if an SLP signs the SSA-538 as the consultant having overall responsibility?

Use the code for Special Senses (44) until we establish a new code specifically for SLPs.

IX-21. In Prototype States, can single decision-makers (SDMs) sign the SSA-538?

No. See the Disability Redesign Prototype Operating Instructions manual. Under the statute, childhood cases must be referred to a medical or psychological consultant. The final rules did not change this requirement.

See DI 24501.001 and §416.1016 concerning who can be a medical or psychological consultant in the DDS.

IX-22.*Why are we now required to write a narrative for each of the six domains? What if the child has no limitation in a domain? (12/00, Q38)

The requirement that we fully explain our functional equivalence findings is not new. We are only providing dedicated space on the form to explain the findings in each domain.

Consideration of a child's functioning starts with the "big picture" of the whole child – what he or she can do, can't do, is limited or restricted in doing, how much help he or she needs, and so on. But once that big picture has been developed, we must decide if the child is disabled, which requires us to consider all the child's impairment-related limitations. So we must consider all domains that might be affected by the interactive and cumulative effects of the child's impairment(s), and show that we did so. We must describe the medical and other findings that support our conclusions and the limitations we find.

This does not necessarily mean we need a narrative for every domain in every case. (This revises what we originally said in Question 38 in the Student Manual for the December 2000/January 2001 Childhood Disability Evaluation Training.) If there are no allegations, and there is no evidence or other indication in the file that a particular domain could be affected by a child's impairment(s), then no narrative is required for that domain. However, be careful. To decide whether a child is disabled, we must fully consider all impairment-related limitations and record enough information that would allow an independent reviewer to see how we evaluated functioning in each domain and how we considered all pertinent factors.

If there is an allegation of a limitation, a narrative is required, because the allegation would have to be refuted in order to find no limitation. If there is an impairment that would ordinarily be expected to cause a limitation within a domain, we need an affirmative statement that the evidence does not show any limitation.

Also, the old principle that we can stop as soon as we make a fully favorable determination continues to apply. Once we document evidence of 1 extreme or 2 marked limitations, there is no need to record additional information in other domains. See also the questions in Topic IV that discuss "Considering Factors that Help Determine How Children Function."

IX-23. Can we write a decision narrative or summary in Section III of the SSA-538 rather than individual domain narratives in Section II?

We want each domain discussed in the spaces provided – that is why we added narrative space for each and put the rating blocks with the narrative. Many of the revisions to the SSA-538 were made to help adjudicators document their evaluation of the "whole child." The format of the SSA-538 helps us ensure that all of the child's limitations are considered.

But we do not want to create double work. Therefore, in some cases it may be appropriate to put some of the domain discussion in Section III and cross-refer to Section II. For example, the summary of how a child's activities and limitations relate to the medical impairments, the resolution of conflicts and credibility may help to explain findings in more than one domain. Since it would be extra work to repeat the same thing in multiple domain sections, some cross-

referring to Section III is appropriate. It is also possible to put some of this information in one of the domain sections and refer back to it in other domains. However, any domain-specific explanation must go in the space provided for that domain.

IX-24. When more than one consultant completes a single SSA-538, should each consultant initial his or her comments in each domain and in Section III?

We do not require this, but it is okay to do this when a DDS finds it helpful. But it is most important to remember that there must be a final overall rating for each domain that takes into account the input from all the consultants.

IX-25. Is the agency going to revise the national age-specific function forms?

Yes, but not immediately. We will look at them soon to determine how to change them to correspond to the new rules and to make other improvements we are considering. But the information collected on the current forms provides plenty of useful information to help evaluate a child's activities at every step of sequential evaluation.

IX-26. Do we need to copy information from the Teacher Questionnaire onto the SSA-538 or can we just reference it?

The SSA-538 is the official statement of record that summarizes the evidence, gives the disposition of the case, and must clearly support the case findings. This does not mean we must copy large amounts of information from documents in file, such as a teacher questionnaire. Rather, we must briefly summarize the relevant information and indicate where it came from. Remember the basic premise of the SSA-538 – the next reviewer must be able to tell from it why we made the determination.

CHILDHOOD QUESTIONS AND ANSWERS
APPENDIX 1 – LIST OF ALL TOPICS AND QUESTIONS

Topic I: Applying the Final Rules

I-1.* Why were the childhood rules changed and what are the changes based on? (12/00, Q2)
I-2.* Do the final rules change the statutory standard for childhood disability? (12/00, Q1)
I-3. Do the final rules change the sequential evaluation process?—
I-4.* When do we start using the new rules? (12/00, Q3)
I-5.* What happens to cases in the pipeline? (12/00, Q4)
I-6. What should an administrative law judge (ALJ) do when a court orders the judge to use the old rules for part or all of the period?
I-7.* Will we have to readjudicate cases using the final rules? (12/00, Q5)
I-8.* What effect will the final rules have on the number of allowances and denials? (12/00, Q9)
I-9.* Do the final rules require more case development? (12/00, Q10)
I-10.* Do the final rules apply to title II disabled child claims? (1997)
I-11. Do the final rules affect age-18 redeterminations?
I-12. Do the final rules have any special implications for prototype states?
I-13.* Do the process unification SSRs and training apply to these cases? (1997)
I-14. Can we use the functional equivalence domains at Step Two to determine whether the child has a severe impairment(s)?
I-15. Are we required to make a finding about the credibility of an individual's statements about symptoms for all cases or only functional equivalence (FE) cases?
I-16. We followed the IVT training pretty closely, but we want to know more. What do we do next?

Topic II: Processing Childhood Cases

II-1. Can we still use earlier training manuals?
II-2.* Do the Disability Digests continue to apply? (12/00, Q40 & 1997)
II-3. Is the guidance in SSR 98-1p about cognitive and speech limitations that medically equal listing 2.09 still in effect?
II-4. Will the agency revise any notices?
II-5. EM- 00187 said to use medical list number (MLN) 107.30 in block 23 on the SSA-831 and block 12 on the SSA-832 for functional equivalence allowances and continuances, but that was only supposed to be until mid-February. What do we put in those blocks on the SSA-831 and SSA-832 now?
II-6. Is there a "grace period" on errors?
II-7. What quality reviews are planned?
II-8. Do the final rules affect the way we adjudicate SSI claims for children under Acquiescence Rulings (ARs)?
   II-8a. How should we apply the *Chavez* AR when adjudicating a child's SSI claim?
   II-8b. How should we apply the *Albright* AR when adjudicating a child's SSI claim?
   II-8c. How should we apply the *Drummond* AR when adjudicating a child's SSI claim?

II-9. Will we need to use more consultants to determine each case?
II-10.* What are the Individualized Family Service Plan (IFSP), the Individualized Education Program (IEP) and the IEP statement of transition service needs and how do we use them? (12/00, Q16)
II-11. Is it correct to say that information from early intervention programs and schools is now more important to help adjudicate cases?
II-12.* Why do we need to request information from early intervention and pre-school programs? (12/00, Q17)
II-13.* If school information is not readily available, especially during summer months, should we hold a case for this functional information? (1997)

Topic III: Establishing Medically Determinable Impairments (MDIs)

III-1.* Why does the "nonsevere" step now also require a finding about the existence of a medically determinable impairment(s)? (12/00, Q6)
III-2. Does it matter why a child has a medically determinable impairment? For example, if family circumstances contribute to the child's condition, how do we evaluate that factor?
III-3.* What sources can establish the existence of a medically determinable impairment? (12/00, Q7)
III-4.* Who can submit evidence about the severity of an impairment(s)? (12/00, Q8)
III-5. How do we evaluate a child who is having trouble in school, but has no medically determinable impairment that explains his or her problems?

Topic IV: Considering Factors That Help Determine How Children Function

IV-1. When we rate limitations, how do we consider the child's ability to function independently?
IV-2.* Why do we have a specific factor about "extra help" since most children, including those without impairments, get help from their parents, teachers and others? (12/00, Q13)
IV-3.* Why am we required to consider how a child would function outside a structured or supportive setting? (12/00, Q14)
IV-4. If we have no information about how a child would function outside a structured setting or without extra help, how can we determine the extent of the child's limitation?
IV-5. What do the regulations mean by the reference to considering "the standards used by the person who gave us the information"?
IV-6.* What activities should we use to compare the functioning of children who have impairments with that of children who do not? (12/00, Q11)
IV-7. When evaluating a child who's in the 6th grade, but who functions like a 4th grader, what age group do we use when considering the child's ability to function?
IV-8.* Why do we need to know that a child may function differently in an unusual setting? (12/00, Q15)
IV-9. We were previously told that we should not punish a child for not taking medications. Does this mean that under no circumstances should we deny a child's eligibility if parents withhold treatment?
IV-10.*Why do the regulations emphasize the need to evaluate the combined effects of multiple impairments? (12/00, Q12)

IV-11. How do we consider the interactive and cumulative effects of impairments?
IV-12. When we rate the cumulative effects of impairments, how do we rate multiple impairments that are "not severe" in the same domain?

Topic V: Using Functional Equivalence Rules

V-1.* Who makes the finding of functional equivalence? (1997)
V-2. In OHA, is an updated medical opinion required to make a determination of functional equivalence?
V-3.* Why were the four functional equivalence methods replaced with only one? (12/00, Q18)
V-4. Have we returned to the old individualized functional assessment (IFA)? (12/00, Q19)
V-5.* Why are the functional equivalence domain names different from the ones used to evaluate childhood mental disorders? (12/00, Q20)
V-6.* How do the new domains avoid the previous concerns about possibly "double weighting" the same impairments? (12/00, Q21)
V-7. Does "delinking" functional equivalence from the listings mean we do not need to establish a medically determinable impairment for functional equivalence (FE) cases?
V-8.* Why are there still functional equivalence examples? (12/00, Q30)
V-9.* Can a mental impairment functionally equal the listings? (12/00, Q29)
V-10. When a child's mental impairment(s) does not meet or medically equal a mental listing, do we need to begin the process again to evaluate the functional equivalence domains?

Topic VI: Using Domains to Assess Children's Activities

A. General

VI-A1.* Must consultants in particular specialties or disciplines evaluate certain domains? For example, are there domains (e.g., Interacting and relating with others) that must always be rated by a psychiatrist or psychologist even if the only established impairments are physical? (12/00, Q22)
VI-A2.* What is the purpose of the lists of typical activities for children of different ages and the lists of limitations in the domain descriptions? (12/00, Q23)
VI-A3.* Must we develop evidence that addresses each of the examples of typical activities? (12/00, Q24)
VI-A4.* Should adjudicators still consider evidence about behavior? (12/00, Q33)
VI-A5. How should an adjudicator evaluate limitations due to a child's impulsivity?
VI-A6.* Where do we evaluate vision and hearing impairments that do not meet or medically equal a listed impairment? (12/00, Q28)

B. Acquiring and using information

VI-B1. Can academic difficulties alone constitute a marked or extreme limitation in "Acquiring and using information?"
VI-B2. Do we consider receptive language under "Acquiring and using information" and expressive language and articulation under "Interacting and relating with others?"

C. Attending and completing tasks

VI-C1. How do "Attending and completing tasks" and "Caring for yourself" apply to children under age 3?
VI-C2. Is "Attending and completing tasks" about completing age-appropriate tasks or completing tasks in an age-appropriate manner?
VI-C3. If a child has juvenile rheumatoid arthritis and has marked limitations in "Moving about and manipulating objects," can the child's slow handwriting also count as a marked limitation in "Attending and completing tasks?"
VI-C4.* What is the difference between the factor "How well [a child] can initiate, sustain and complete activities" and the domain "Attending and completing tasks"? (12/00, Q31)

D. Interacting and relating with others

VI-D1. Assume a child has a medically determinable personality disorder that is manifested by limitations in "Interacting and relating with others." The child demonstrates behavior that is destructive to others such as parents, teachers, bus drivers and coaches. Can a child qualify under the functional equivalence rules if there are no other relevant facts or circumstances?
VI-D2. The regulations incorporate language activities as part of "Interacting and relating with others." Please comment on why language is part of Interacting and relating.
VI-D3. Does a "marked" or "extreme" limitation in speech under the tables in SSR 98-1p lead to a "marked" or "extreme" limitation in "Interacting and relating with others" even if all other aspects of that domain are less than marked?
VI-D4. What about the child who has a marked limitation in speech, but has normal pragmatic language abilities? Is "Interacting and relating" still rated as "marked?"
VI-D5. Under "Interacting and relating with others," what do we mean by "the language of your community" as it pertains to a child who is non-English-speaking or who is bilingual?

E. Moving about and manipulating objects

VI-E1. Does "Moving and manipulating objects" cover the effects of mental impairments?

F. Caring for yourself

VI-F1. What is the scope of "Caring for yourself?"

G. Health and physical well-being

VI-G1.* Why is there a domain just for "Health and physical well-being"? (12/00, Q27)
VI-G2.* What is the difference between assessing the effects of chronic illness and treatment throughout the sequential evaluation process and assessing a child's "Health and physical well-being?" (12/00, Q32)
VI-G3. What is definition of "exacerbation" and how do we know when an episode begins or ends?

VI-G4. How do we distinguish "Moving about and manipulating objects" and "Health and physical well-being"?
VI-G5. Do we include episodes of ear infection, tonsillitis and leg pain in "Health and physical well-being"?
VI-G6. Does "Health and physical well-being" cover the effects of a mental impairment?
VI-G7. Should we rate asthma cases in "Health and physical well-being"?
VI-G8. The regulations describing the domain of "Health and physical well-being" list "psychomotor retardation" as a "physical effect" that should be considered under this domain. What does this mean?

Topic VII: Rating "Marked" and "Extreme" Limitations

VII-1.* Why are the words "seriously" and "very seriously" used in the general definitions of "marked" and "extreme"? (12/00, Q34)
VII-2.* If a child has a major problem with one activity in a domain, does this mean the child has a "marked" limitation in that domain? (12/00, Q25)
VII-3.* When a child is limited in more than one activity in the same domain, can we rate the domain as "marked"? (12/00, Q26)
VII-4. How do we convert considerations about a child's functioning to ratings of severity? If we can use all the other non-standard sources of information about functioning, do we still need to have all the previous "program standard evidence" like particular IQ tests or speech or language tests in order to make the assessment?
VII-5. If a child has marked limitations in both receptive and expressive language, will those limitations functionally equal a listing?
VII-6.* Why does "Health and physical well-being" have an alternative way to rate severity? (12/00, Q35)
VII-7. How do we judge what is "substantially in excess of a "marked" limitation to find an "extreme" limitation in "Health and physical well-being?"
VII-8. Will a child who has multiple episodes of unrelated illness that lasted 2 weeks each have a marked limitation in "Health and physical well-being?"
VII-9. Do the new definitions of "marked" and "extreme" for functional equivalence change any specific listing criteria that also include frequency of attacks, like asthma?

Topic VIII: Processing Continuing Disability Reviews (CDRs)

VIII-1. How do we do CDRs?
VIII-2. If there is no medical improvement (MI) at CDR, must we describe all findings on the SSA-538 or can we just complete the first page?
VIII-3. A CDR reconsideration file in the Disability Hearing Office (DHO) ordinarily includes an advisory SSA-538 from the DDS. If the advisory SSA-538 is the old version, does the DHO need to request a new one?
VIII-4. What form will DHOs use for childhood CDR cases?
VIII-5.* Explain the "show treatment" provision. How do we do this? (1997)

Topic IX: Completing Revised Form SSA-538 and Other Children's Forms

IX-1.* Now that the revised SSA-538 is two pages longer than the old version, how long will it take us to complete it? (12/00, Q39)
IX-2.* Why are we required to provide more explanations on the revised SSA-538? (12/00, Q36)
IX-3. Why is so much policy information included on the SSA-538?
IX-4.* Can the SSA-538 serve as a formal rationale in lieu of the SSA-4268? (1997)
IX-5. What is the appropriate way to delete or revise material on the SSA-538?
IX-6.* Can a disability examiner assist in the completion of the SSA-538?
IX-7. How should we complete the SSA-538 when a child has multiple problems, but they are not all considered "severe" impairments?
IX-8.* May we reference the initial SSA-538 on the reconsideration SSA-538 when no new evidence is presented? (1997)
IX-9.* Why are the disability hearing officers, ALJs and the Appeals Council not required to complete the SSA-538? (1997)
IX-10.*If a child attains age 18 after filing an application but prior to a determination, do we complete the SSA-538? (1997)
IX-11.*Where do we file the SSA-538 in the 6-part claims folder? (1997)
IX-12. Why was the "engaging in SGA" question added to the top of the SSA-538?
IX-13. Why does DI 25230.005A tell us to list both medically determinable impairments (MDIs) and any impairments recorded but *not* established as MDIs on the SSA-538?
IX-14. If the child qualifies under one of the Examples in the FE rules, do we still need to complete the back of the form?
IX-15. Do we still need to complete an SSA-538 for "failure to cooperate" determinations?
IX-16.*Why are consultants required to affirm that they considered "Factors" and "Evidence" when completing the SSA-538? (12/00, Q37)
IX-17.*Why does the SSA-538 now require a consultant to sign as having "overall responsibility" for the case findings? (1997)
IX-18. In a denial, when a physician has overall responsibility in a case involving a combination of both physical and mental impairments, does a psychologist or psychiatrist have to review the case and sign off on the SSA-538?
IX-19. If a child has a marked limitation in "Interacting and relating" because of a speech impairment alone, is the speech-language pathologist (SLP) allowed to rate the domain independently or does a psychologist make that call?
IX-20. What MCS Specialty Code should be used on the SSA-831 or SSA-832 if an SLP signs the SSA-538 as the consultant having overall responsibility?
IX-21. In Prototype States, can single decision-makers (SDMs) sign the SSA-538?
IX-22.*Why are we now required to write a narrative for each of the six domains? What if the child has no limitation in a domain? (12/00, Q38)
IX-23. Can we write a decision narrative or summary in Section III of the SSA-538 rather than individual domain narratives in Section II?
IX-24. When more than one consultant completes a single SSA-538, should each consultant initial his or her comments in each domain and in Section III?
IX-25. Is the agency going to revise the national age-specific function forms?
IX-26. Do we need to copy information from the Teacher Questionnaire onto the SSA-538 or can we just reference it?

CHILDHOOD QUESTIONS AND ANSWERS
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