Federal Register

Monday,
August 21, 2000

Part II

Social Security Administration

20 CFR Parts 404 and 416

Revised Medical Criteria for Evaluating Mental Disorders and Traumatic Brain Injury; Final Rules

Rescission of Social Security Acquiescence Rulings 92–3(4), 93–1(4) and 98–2(8); Notice

SOCIAL SECURITY ADMINISTRATION

20 CFR Parts 404 and 416

[Regulation Nos. 4 and 16]

RIN 0960–AC74

Revised Medical Criteria for Evaluating Mental Disorders and Traumatic Brain Injury

AGENCY: Social Security Administration.

ACTION: Final rules.

SUMMARY: These rules revise our regulations for evaluating mental impairments. They also change some of the provisions of our Listing of Impairments (the Listings) that we use to evaluate mental disorders in adults. We also are adding guidance to the adult neurological listings regarding the evaluation of traumatic brain injury. In addition, the rules make technical changes to the adult digestive listings and the childhood mental disorders listings. We expect that these rules will clarify the intent and purpose of the listings for evaluating mental disorders, and will simplify our adjudication of claims involving mental impairments. These rules also recognize the sometimes unpredictable course of traumatic brain injury, and will improve our adjudication of claims involving traumatic brain injuries.

DATES: These rules are effective September 20, 2000.

FOR FURTHER INFORMATION CONTACT: Deborah Barnes, Social Insurance Specialist, Office of Disability, Social Security Administration, 3-B–8 Operations Building, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–4171, email deborah.barnes@ssa.gov, or TTY (410) 966–5609. For information on eligibility, claiming benefits, or coverage of earnings, call our national toll-free number, 1–800–772–1213 or TTY 1–800–325–0778.

SUPPLEMENTARY INFORMATION:

Background

Title II of the Act provides for the payment of disability benefits to three groups of individuals: Workers insured under the Act; children of insured workers; and widows, widowers, and surviving divorced spouses of insured workers. Title XVI of the Act provides for supplemental security income (SSI) payments on the basis of disability to adults and to children. For individuals claiming title II disability benefits and for adults claiming SSI disability payments, ''disability'' means the inability to do any substantial gainful activity (SGA). We will consider a child claiming SSI disability payments ''disabled'' if he or she has an impairment(s) that causes ''marked and severe functional limitations.'' Under both title II and title XVI, disability must be by reason of a medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of at least 12 months.

The Listings describe, for each of the major body systems, examples of impairments we consider severe enough to prevent an adult from doing any gainful activity, or that cause marked and severe functional limitations in a child. The Listings are divided into part A and part B. We apply the medical criteria in part A when we assess the claims of adults. We may also use the criteria in part A when we evaluate SSI childhood disability claims if the disease processes have a similar effect on both adults and children. However, when we evaluate childhood disability claims, we first use the criteria in part B; if those criteria do not apply, we then use the criteria in part A. (See §§ 404.1525 and 416.925).

We last published final rules containing comprehensive revisions to the adult mental disorders listings in the **Federal Register** on August 28, 1985 (50 FR 35038). In the preamble to those rules, we indicated that medical advancements in disability evaluation and treatment and program experience would require that the mental disorders listings be periodically reviewed and updated. We published a Notice of Proposed Rulemaking (NPRM) on July 18, 1991 (56 FR 33130), and invited interested persons, organizations, and groups to submit their comments on the NPRM within 60 days.

We received over 120 letters from individuals and groups commenting on the proposed rules. The commenters generally supported most of the proposed changes, but objected to certain aspects of the proposed rules.

We have carefully considered all of the public comments and are adopting parts of the proposed rules with modifications. Since we published the NPRM, there have been both medical and legislative changes that require us to review some of our proposed revisions again. For example, the American Psychiatric Association's publication of the Fourth Edition of the ''Diagnostic and Statistical Manual of Mental Disorders'' (DSM-IV) in May 1994 impacts directly on our proposal to incorporate terminology from the DSM Third Edition-Revised (DSM-III-R). The changes made to the childhood disability program by Public Law 104–193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, affects our proposal to extend use of the special technique for evaluating mental impairment severity to childhood mental disorders claims evaluated under part B of the Listings.

Consequently, we are deferring action on the proposed revisions that are not finalized by these regulations. We are not incorporating DSM-III-R terminology or establishing a new psychoactive substance dependence listing (listing 12.09) with its own paragraph A diagnostic criteria and paragraph B functional criteria. We are reassessing this latter proposal as a result of the provisions of Public Law 104–121 that prohibit eligibility for disability benefits when drug addiction or alcoholism (DAA) is a contributing factor material to the determination of disability. We are not incorporating the ''capsule definition'' into the paragraph A diagnostic criteria of each listing, although we have addressed the relevance of the capsule definition in these final rules. We are not providing definitions of the scale points in §§ 404.1520a and 416.920a or expanding application of the special technique we use to evaluate adult mental disorders to the childhood mental disorders listings. Finally, we are not adding criteria to listing 12.07 to address eating and tic disorders.

In these final rules, we are revising the third and fourth paragraph B functional criteria in each listing. We are adding paragraph C functional criteria to listings 12.02 (Organic Mental Disorders) and 12.04 (Affective Disorders). We are standardizing at two the number of paragraph B criteria that an impairment must satisfy to meet a listing. In §§ 404.1520a and 416.920a, we are modifying the B criteria rating scales and the requirements for documenting application of the technique at all review levels. We also are deleting certain provisions that address issues that already are covered in other regulations. We are adding a new paragraph F in the introductory text to the neurological listings that discusses the evaluation of traumatic brain injury. We also are making changes to and reorganizing the introductory text to the mental disorders listings.

We discuss below the significant differences between the proposed rules and final rules. We also respond to the significant public comments on these final rules. We will consider the public comments we received on the proposed revisions that we are not finalizing by

these regulations as we reassess those proposals.

The revised adult mental disorders listings (and other listings) in these rules will be effective until July 2, 2001, unless they are extended by the Commissioner or revised and promulgated again.

Explanation of the Final Rules

Sections 404.1520a and 416.920a Evaluation of Mental Impairments

We revised and clarified our rules in these sections on the procedure we use to evaluate the severity of mental impairments. We made revisions in response to public comments, to clarify the proposed language, and for technical reasons. However, the final rules do not include our proposal to expand application of the technique to include evaluation of mental impairment severity under the childhood mental disorders listings. The final rules also do not provide definitions for the scale points, as we proposed. As in the NPRM, we use the term ''technique'' throughout these sections to facilitate our discussion of this procedure.

Final §§ 404.1520a(a) and 416.920a(a), ''General,'' are essentially the same as in the prior rules, except for editorial changes that reflect our decision not to apply the technique to childhood mental disorders claims evaluated under part B of the Listings.

Final §§ 404.1520a(b) and 416.920a(b), ''Use of the technique,'' provide basic information about the application of the technique. They explain that we must first evaluate the evidence to determine whether an individual has a medically determinable mental impairment(s), demonstrated by pertinent symptoms, signs, and laboratory findings. If we determine that an individual has a medically determinable mental impairment(s), we must specify the symptoms, signs, and laboratory findings substantiating its presence. Then, we will rate the degree of functional limitation resulting from that impairment(s) and record our findings as set out in §§ 404.1520a(c) and (e) and 416.920a(c) and (e).

In the final rules, we simplified proposed §§ 404.1520a(b)(1) and 416.920a(b)(1), which contained a number of sentences addressing different issues. Final §§ 404.1520a(b)(1) and (b)(2) and 416.920a(b)(1) and (b)(2), which describe the basic technique, contain the first four sentences of proposed §§ 404.1520a(b)(1) and 416.920a(b)(1), with minor editorial changes.

We deleted the fifth sentence of proposed §§ 404.1520a(b)(1) and 416.920a(b)(1) because it was redundant of the fourth sentence. We also deleted the seventh sentence, which referred to the evaluation of childhood mental impairments. We incorporated the sixth sentence, which describes how we rate the degree of functional limitation, in final §§ 404.1520a(c) and 416.920a(c).

We incorporated the four sentences in proposed §§ 404.1520a(b)(2), with some revisions, in final §§ 404.1520a(c)(3) and (4) and 416.920a(c)(3) and (4). Final §§ 404.1520a(b)(2) and 416.920a(b)(2) now state that we must rate the degree of limitation in accordance with final §§ 404.1520a(c) and 416.920a(c) and record our findings as set out in final §§ 404.1520a(e) and 416.920a(e).

We deleted proposed §§ 404.1520a(b)(3) and 416.920a(b)(3) in which we had defined the rating scale points for each of the first three functional areas. We also deleted proposed §§ 404.1520a(b)(4) through (7) and 416.920a(b)(4) through (7) in their entirety, since they addressed rating scale points for assessing the degree of limitation for childhood mental impairments evaluated under part B of the Listings.

As we explain in more detail in the public comments section of this preamble, we expanded final §§ 404.1520a(c) and 416.920a(c), ''Rating the degree of functional limitation,'' to respond to many comments we received about the technique. In final §§ 404.1520a(c)(1) and 416.920a(c)(1), we explain that the assessment of functional limitations is a complex and highly individualized process requiring consideration of multiple issues. We stress that in addition to symptoms, signs, and laboratory findings, we consider other factors, such as the effects of chronic mental disorders, structured settings and the effects of medication and other treatment. We also stress that we must consider the individual's functioning over time.

We provide further detail about these principles in final §§ 404.1520a(c)(2) and 416.920a(c)(2). The first sentence explains that when we rate the degree of functional limitation, we consider the extent to which the individual's impairment or combination of impairments interferes with the ability to function independently, appropriately, effectively, and on a sustained basis. The second sentence explains that we will consider factors including the quality and level of the individual's overall performance, any episodic limitations, the amount of supervision or assistance required, and the settings in which the individual can function. The third sentence provides a cross-reference to 12.00C through 12.00H of the introductory text to the adult mental disorders listings for more information about the factors we consider.

Final §§ 404.1520a(c)(3) and 416.920a(c)(3) are based on the first sentence of proposed §§ 404.1520a(b)(2) and 416.920a(b)(2). They list the four functional areas we consider (activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation) when we employ the technique.

Final §§ 404.1520a(c)(4) and 416.920a(c)(4) explain that we will use a five-point scale (none, mild, moderate, marked, and extreme) when we rate the degree of limitation in the first three functional areas (i.e., all but ''episodes of decompensation''). We also include the statement from the last sentence of §§ 404.1520a(b)(3) and 416.920a(b)(3) of the prior rules, which we had included in the NPRM. However, we revised the statement in response to comments. Instead of providing that the last two points of the five-point rating scale represent degrees of limitation that are incompatible with the ability to do a work-related function, the final rules provide that the last point of the scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. We explain our reasons for this change in the public comments section of this preamble.

Final §§ 404.1520a(d) and 416.920a(d), ''Use of the technique to evaluate mental impairments,'' correspond to prior §§ 404.1520a(c) and 416.920a(c) and proposed §§ 404.1520a(c) and 416.920a(c). In the final rules, we revised the language that related to proposed changes in the rating scale points and deleted proposed §§ 404.1520a(c)(2) and 416.920a(c)(2) in their entirety.

Final §§ 404.1520a(d)(2) and 416.920a(d)(2), which explain how we determine whether an impairment meets or is equivalent in severity to a mental listing, correspond to prior §§ 404.1520a(c)(2) and 416.920a(c)(2) and proposed §§ 404.1520a(c)(3) and 416.920a(c)(3). In response to a comment, the final rules contain the first sentence of prior §§ 404.1520a(c)(2) and 416.920a(c)(2), slightly edited. The sentence explains that we will determine whether an impairment meets or is equivalent in severity to a listing if we first determine that the individual has a severe impairment(s). We also revised the second sentence slightly for context.

Final §§ 404.1520a(d)(3) and 416.920a(d)(3) correspond to prior §§ 404.1520a(c)(3) and 416.920a(c)(3)

and proposed §§ 404.1520a(c)(4) and 416.920a(c)(4). These sections explain that we will make a residual functional capacity (RFC) assessment whenever an individual has a severe impairment or combination of impairments that neither meets nor is equivalent in severity to any listing. In the NPRM, we had replaced the reference to a ''residual functional capacity'' assessment with a more generic reference to a functional assessment in order to include children. Also in response to a comment, we further revised the sentence proposed in the NPRM and deleted the last phrase (''when appropriate to the category of claim being assessed''). The phrase suggested that in some cases we would not do RFC assessments of individuals who have severe impairments that neither meet nor are equivalent in severity to any listed impairment. In fact, we always do RFC assessments in these circumstances.

Final §§ 404.1520a(e) and 416.920a(e), ''Documenting application of the technique,'' correspond to prior §§ 404.1520a(d) and 416.920a(d), ''Preparation of the document,'' and proposed §§ 404.1520a(d) and 416.920a(d). The final rules, like the NPRM, explain that we must complete a standard document showing the application of the technique in each case at the initial and reconsideration levels of the administrative review process. At the hearings and appeals levels, administrative law judges and the Appeals Council must record the application of the technique in their decisions. We revised the heading slightly from the NPRM (from ''this technique'' to ''the technique'') for consistency. We also made editorial revisions in the two sentences that make up the paragraph.

In final §§ 404.1520a(e)(1) and 416.920a(e)(1) (proposed §§ 404.1520a(d)(1) and 416.920a(d)(1)), we clarified the provisions addressing the role of the disability examiner in preparing the standard document. However, we retained the basic provision, which permits the disability examiner to assist the medical or psychological consultant in preparing the form. We describe the revisions and our response to the comments we received on the proposed rules in the public comments section of this preamble. In a technical correction, we revised the opening phrase of the first sentence to make it clearer that the medical or psychological consultant has overall responsibility for assessing medical severity at the reconsideration level except when a disability hearing officer makes the determination. When a reconsideration determination is made by a disability hearing officer, the disability hearing officer has overall responsibility for assessing medical severity.

Final §§ 404.1520a(e)(2) and 416.920a(e)(2) (proposed §§ 404.1520a(d)(2) and 416.920a(d)(2)), which describe what administrative law judges and the Appeals Council must include in their decisions to document the technique, are substantively unchanged from the NPRM. We made minor editorial corrections and revised the cross-references to reflect the organization of the final rules.

We made a number of changes in final §§ 404.1520a(e)(3) and 416.920a(e)(3) (proposed §§ 404.1520a(d)(3) and 416.920a(d)(3)) in response to public comments. We proposed revisions to the procedures under which administrative law judges may return cases to the State agencies. We describe these revisions and our reasons for making them in the public comments section of this preamble. We also made minor, nonsubstantive editorial revisions in the paragraph.

Appendix 1 to Subpart P—Listing of Impairments

11.00F Traumatic Brain Injury (TBI)

As in the proposed rules, the final rules include a new 11.00F in the preface to the adult neurological listings that provides guidance for the evaluation of cases involving traumatic brain injury (TBI). In response to a comment, we changed the heading of the final section from the proposed ''Cerebral trauma.''

TBI cases are evaluated under reference listing 11.18, ''Cerebral trauma.'' Final 11.00F recognizes the sometimes unpredictable course of TBI during the first few months post-injury. Thus, final 11.00F provides three situations for evaluating disability based on alternative possible courses. First, it explains that the neurological impairment may be so profound following the trauma that it will be possible to decide immediately that an individual is disabled. Second, it explains that if there is not such a profound initial neurological impairment, we will defer adjudication of the claim until we obtain evidence of any neurological and mental impairments at least 3 months post-injury. Third, if a finding of disability is still not possible at 3 months post-injury, we will again defer adjudication of the claim until we obtain evidence at least 6 months post-injury.

We made a number of editorial clarifications in final 11.00F, partly in response to comments and partly for clarity and precision of the final language. None of the changes are substantive. For instance, we deleted the word ''listing'' in all but one place to be consistent with the style of other paragraphs of the listings. We also replaced such phrases as ''make a final adjudication'' and ''favorable decision,'' which have other connotations in our program, with more accurate phrases, such as ''adjudicate the claim'' and ''finding of disability.'' Among other changes, we also revised 11.00F to make it clear that an individual with TBI may have a neurological or a mental impairment, or both.

The most extensive editorial revision is to the second paragraph of proposed 11.00F, which consisted of ten sentences that addressed more than one subject. In final 11.00F, we divided the proposed second paragraph into two paragraphs (the second and third paragraphs of final 11.00F). We also reorganized the sentences of the proposed paragraph so that each paragraph addresses one subject. Thus, the second paragraph of final 11.00F includes the first, second, third, fifth, sixth, and seventh sentences of the NPRM, which describe the variable course of TBI. The third paragraph includes the fourth, eighth, ninth, and tenth sentences, which explain when we will proceed with adjudication and when we will defer adjudication.

12.00 Mental Disorders

The final listings do not include all of the substantive revisions we had proposed. The proposed revisions reflected evolving medical knowledge of the characteristics of mental disorders and their treatment and management. They also reflected the program experience we have gained in monitoring and evaluating the prior listings.

For example, in the proposed revisions, we had updated the medical terms used to describe the major mental disorders and their characteristics and symptoms to conform to the nomenclature in the DSM–III–R published by the American Psychiatric Association. The DSM is widely used by psychiatrists, psychologists, and other mental health professionals. It provides a common basis for communication and facilitates our evaluation of medical reports when we make determinations of disability.

The American Psychiatric Association has an ongoing process to update the DSM. The fourth edition of the DSM (DSM–IV) was published in May 1994. We decided to publish these final rules without the changes we had proposed, rather than further delay them to

incorporate any additional changes in the terminology and diagnostic criteria from the DSM–III–R to the DSM–IV. In the meantime, we are reviewing those changes in the DSM–IV that pertain to our listings to determine whether we need to revise these final listings at a future date.

We retained one substantive change from the proposed listings; the final rules make the requirement for limitations in two of the areas under paragraph B the uniform standard for all listings that employ paragraph B functional criteria.

One nonsubstantive change we made from the proposed listings was to separate mental retardation and autistic disorder and other pervasive developmental disorders into two listings, listings 12.05 and 12.10, respectively. We discuss this change in detail in the summary below and in the public comments section of this preamble.

The following is a detailed description of the changes in each section.

12.00 Preface

12.00A Introduction

Final 12.00A, ''Introduction,'' describes the structure of the listings and explains how we apply them. This section also provides guidance about the severity of the listings, how we determine equivalence, and how we determine residual functional capacity (RFC). In the final rules, we updated the list of titles of the listing categories to reflect the change in 12.05 and the addition of 12.10. We also updated the list of listings with paragraph C criteria. In addition, we expanded the discussion regarding the application of the paragraph B and C criteria. We now specify that the evaluation of functional limitations must be done by applying the paragraph B criteria first. We will apply the paragraph C criteria only if we find that the paragraph B criteria are not satisfied. Because final listing 12.09, ''Substance addiction disorders,'' remains a reference listing, we restored the description of the listing found in the prior rules. We also added a description of the structure of listing 12.05, ''Mental retardation,'' because it is the only other listing that does not employ the same paragraph A-paragraph B system as the other mental disorders listings in all of its sections. However, we clarified the proposed description in the final rules in response to public comments about the listing itself. The description in the final rules also reflects the fact that we removed ''autistic disorder and other pervasive developmental disorders'' from listing 12.05 and placed them in a separate listing 12.10. We did this both in response to a public comment and for consistency with the childhood mental disorders listings. We discuss this change in greater detail in the public comments section of this preamble.

We also explain in final 12.00A that the listings contain examples of disorders that are considered severe enough to preclude an individual from doing any gainful activity. If an impairment does not meet the requirements of a listing, we will determine whether the individual's impairment(s) is equivalent in severity to a listed impairment. We revised the discussion regarding determinations of equivalence in the sixth paragraph of final 12.00A because some of the comments about proposed listing 12.09 indicated that there could be confusion about how we evaluate a medically determinable severe mental impairment that does not satisfy all of the paragraph A criteria of a particular listing. The last sentence now states that in such cases, the assessment of the paragraph B and C criteria is critical to a determination of equivalence.

12.00B Need for Medical Evidence

Final 12.00B, as in the prior rules, repeats basic principles of disability evaluation that are set out in the regulations, but focuses specifically on the evaluation of mental disorders. It describes the need to establish the existence of a medically determinable impairment of the required duration, and defines the terms ''symptoms'' and ''psychiatric signs.'' It also explains that symptoms and signs generally cluster together to constitute the recognizable mental disorders described in the listings. This section also provides a reminder that symptoms and signs may be intermittent or continuous.

In response to a comment, we revised the third sentence of proposed 12.00B to indicate that the specific psychological abnormalities named in the sentence are only examples of such abnormalities. The sentence does not contain an all-inclusive list. We also revised the examples of abnormalities in response to a comment and updated the terminology. We also deleted the example of psychiatrists and psychologists as appropriate medical sources. We describe all of these changes in the public comments section of this preamble.

12.00C Assessment of Severity

This section explains how we assess severity under the listings using the paragraph B and C functional criteria. It briefly defines the term ''marked'' and describes each of the four functional areas in detail. Throughout final 12.00C, as in the NPRM, we incorporated references to the ability to sustain function. This reflects more clearly our longstanding policy that the ability to sustain function is essential to the effective performance of the function.

The opening paragraph of final 12.00C is substantively the same as in the prior rules. As in the NPRM, we simplified and clarified it without any change in meaning. In response to a comment, we replaced the descriptive ''ability to tolerate increased mental demands associated with competitive work or other stressful circumstances,'' with the more accurate and simpler heading of the fourth functional criterion, ''episodes of decompensation,'' in the list of the four functional areas. We explain our reasons for this revision in the public comments section of this preamble under the comments about 12.00C4. We also moved the cross-reference to §§ 404.1520a and 416.920a to the end of the paragraph.

Final 12.00C1 describes the first paragraph B criterion, activities of daily living. The final paragraph is different from the prior rules in only one respect. The example at the end of the second paragraph of the section in the prior rules was too narrow; therefore, we had revised the example in the NPRM. In response to a comment about that revised example, however, we replaced it with a more comprehensive and descriptive example.

Final 12.00C2 describes the second paragraph B criterion, social functioning. Except for editorial changes, the final paragraph is the same as the prior rules and the NPRM.

Final 12.00C3 describes the third paragraph B criterion, concentration, persistence, or pace. The title of the final paragraph does not reflect the change we had proposed in the NPRM, ''Task completion.'' However, we made it consistent with §§ 404.1520a, 416.920a, and the listings themselves by changing the ''and'' to ''or.'' The final paragraphs incorporate most of the proposed revisions. We also clarified how we assess concentration, persistence, or pace in work evaluations.

The prior paragraph 12.00C3 consisted of eight sentences. We simplified final 12.00C3 by dividing the sentences into separate paragraphs. In addition, we made a number of revisions in the final rules in response to public comments. Besides revising the proposed text in response to the comments, we also added two paragraphs to the final rules. The

revisions remove the example of ''everyday household routines'' in the first paragraph of proposed 12.00C3, and explain that an individual's ability to function in settings other than work settings is important. They also provide more information about how we evaluate such activities. The revisions provide guidance about the need to consider all relevant evidence, and such factors as whether the individual is functioning in a structured setting. In addition, we clarified that we meant our reference in the first paragraph of proposed 12.00C3 to ''direct psychiatric examination'' to include clinical examinations performed by psychologists. We also restored the three examples of work tasks from the prior rules, and we added a reference to ''serial threes'' as a test of concentration. We describe all of these changes in detail, and our reasons for making them, in the public comments section of this preamble.

Final 12.00C4 describes the fourth paragraph B criterion, and the first paragraph C criterion, episodes of decompensation. As in the NPRM, we deleted the reference to ''work or work-like settings'' because episodes occurring outside these settings can be equally useful in assessing an individual's ability to work and because, as a practical matter, the information in cases does not often come from observations in work or work-like settings.

We substantially revised final 12.00C4 in response to many public comments we received about the section itself and about the paragraph B and C criteria in the proposed listings. Final 12.00C4 now contains two paragraphs. The first paragraph defines ''episodes of decompensation,'' without the proposed phrase, ''causing deterioration.'' We also revised the proposed definition to make clear that episodes of decompensation are accompanied by a loss of adaptive functioning, instead of stating that such episodes ''may include'' loss of adaptive functioning, as we had proposed. A new second sentence in the first paragraph explains that episodes of decompensation may be demonstrated by an exacerbation in symptoms or signs that would ordinarily require increased treatment, or a less stressful situation (which can include withdrawal from the stressful situation), or a combination of the two. Such an episode may be shown by significant alteration in medications, documentation of the need for a more structured psychological support system, or other relevant information.

We also added a new second paragraph in final 12.00C4. The first sentence introduces and defines the term, ''repeated episodes of decompensation, each of extended duration.'' In the final rules, we used this term in each of the paragraph B4 and C1 listing criteria instead of repeating the requirement, as we had proposed in the NPRM, that the episodes of decompensation average three times within 1 year or once every 4 months, and each last for at least 2 weeks. We provide guidance in the second sentence of this new paragraph for evaluating episodes of decompensation that occur less frequently than three times in a year or once every 4 months but last longer than 2 weeks, or that are of shorter duration but occur more frequently.

We made all of the changes in final 12.00C4 in response to comments. We describe the comments and give our reasons for making these changes in the public comments section of this preamble under the heading for 12.00C4 and under the heading for listing 12.02, where we discuss all of the general comments about the paragraph B4 and C1 criteria in the listings.

12.00D Documentation

As in the NPRM, we greatly expanded final 12.00D from the prior rules to provide guidance about several aspects of the documentation of claims involving mental disorders. We made many changes in the final rules in response to comments, most of which we describe in the public comments section of this preamble.

In response to the comments, we reorganized and simplified the final section. Proposed 12.00D contained 24 paragraphs, none of which had headings, or number or letter designations. As a result, the proposed section was somewhat cumbersome and some of the comments indicated to us that it needed an internal structure.

Proposed 12.00D addressed a number of different topics that all fall under the heading, ''Documentation,'' but are otherwise separate topics. The first four and one-half paragraphs of the proposed section discussed general issues associated with the development of claims: Requirements to obtain medical evidence to establish the existence of a medically determinable impairment; the value of information from the individual and others who know the individual; the need to establish a longitudinal record because of variations in functioning; the relevance of work; and the purchase of consultative examinations employing psychometric testing. From the middle of the proposed fifth paragraph through the proposed eighteenth paragraph, we provided technical discussions about psychological testing, including two paragraphs devoted to neuropsychological testing. The nineteenth through twenty-fourth paragraphs primarily discussed issues related to the documentation of particular disorders.

Aside from the fact that reference to the numerous unnumbered paragraphs in the section was difficult, our proposal grouped together different topics without any indication that they addressed more-or-less distinct subjects. This unstructured organization confused some commenters about our intent in several areas. Therefore, in response to the comments, we provided headings and number or letter designations for each of the paragraphs wherever we believed that they would help clarify the rules. The final rules are structured as follows.

The opening paragraph of final 12.00D is based on the first paragraph of prior 12.00D and the first paragraph of proposed 12.00D and includes new provisions that we added in response to a comment. The paragraph provides general guidance that the documentation in a claim must include sufficient evidence to establish the existence of a medically determinable mental impairment(s), to assess the degree of functional limitation the impairment(s) imposes, and to project the probable duration of the impairment(s). It also provides a cross-reference to §§ 404.1512 and 416.912, which define the term ''evidence'' and describe the various individuals, institutions, and agencies that can provide evidence. These regulatory sections also explain the efforts we will make to assist individuals in obtaining existing evidence or in developing evidence (such as through a consultative examination) for their claims.

The remainder of the opening paragraph of final 12.00D provides three reminders of longstanding policies in our regulations that we apply to all individuals, not just those with mental impairments. First, the medical evidence must be sufficiently complete and detailed to permit an independent determination. Second, we should consider information from other relevant sources (including nonmedical sources) in determining how an individual's medically determinable impairment(s) affects his or her ability to function. Third, we will consider all relevant evidence in the case record.

Final 12.00D1, ''Sources of evidence,'' is divided into three parts. Final 12.00D1a, ''Medical evidence,'' explains that we must have evidence from an acceptable medical source showing that an individual has a medically

determinable mental impairment. It further provides that we will make every reasonable effort to obtain all relevant and available medical evidence about an individual's mental impairment. It also explains that, whenever possible, and appropriate, medical source evidence should reflect the source's consideration of information from the individual and other concerned persons who are aware of the individual's functioning. In accordance with standard clinical practice, any medical source assessment of an individual's mental functioning should take into account sensory, motor, or communication abnormalities and the individual's cultural and ethnic background. These provisions are based on the third sentence of the first paragraph and part of the last sentence of the third paragraph of proposed 12.00D, but are significantly expanded and revised.

Final 12.00D1b, ''Information from the individual,'' corresponds to the first two sentences of the second paragraph of proposed 12.00D, which we revised in response to comments. It now explains that individuals with mental impairments can often provide accurate descriptions of their limitations, but recognizes that some individuals may not be willing or able to fully describe their limitations. Therefore, we must carefully examine statements from each individual to determine if they are consistent with the other evidence of record and to determine whether we need additional information about the individual's functioning from the individual or from other sources.

Final 12.00D1c, ''Other information,'' corresponds to the third and fourth sentences of the second paragraph and the last sentence of the third paragraph of proposed 12.00D. It explains how we consider information from other health care providers, records from work evaluations and rehabilitation progress notes, and lay sources, such as family members.

Final 12.00D2, ''Need for longitudinal evidence,'' corresponds to most of the third paragraph of proposed 12.00D. We explain that an individual's level of functioning may vary considerably over time, so that functioning at a specific time—regardless of whether it is adequate or poor—may not be an accurate indicator of the overall severity of the individual's impairment(s). This section explains that proper evaluation of the impairment(s) must take into account any variations in the level of functioning. It also explains that it is vital to obtain evidence from relevant sources over a sufficiently long period to establish impairment severity. Apart from minor editorial revisions, the final paragraph is unchanged from the NPRM.

Final 12.00D3, ''Work attempts,'' corresponds to the fourth paragraph of proposed 12.00D. In response to a comment, we added a sentence reminding adjudicators to consider the degree to which an individual requires special supports, such as those provided through supported employment or transitional employment programs, in order to work. Otherwise, the substance of the final paragraph is unchanged from the NPRM.

Final 12.00D4, ''Mental status examination,'' is a new paragraph that we added in response to a comment. It describes the components of mental status examinations and the circumstances under which such examinations are performed.

Final 12.00D5, ''Psychological testing,'' consists of three paragraphs. Final 12.00D5a corresponds to the third sentence of the fifth paragraph of proposed 12.00D. It explains the reference to ''a standardized psychological test'' in these listings and what we mean by the term ''qualified'' specialist. We also divided the proposed sentence into two sentences and clarified our intent.

Final 12.00D5b provides guidance about the general kinds of information one can expect to elicit from psychological tests. It begins with a sentence that is based on the last sentence of the fifth paragraph of proposed 12.00D, which we revised in response to a comment. We now state that psychological tests elicit a range of ''responses,'' rather than ''behaviors.'' The paragraph finishes with the provisions from the first two sentences of the ninth paragraph of proposed 12.00D. These sentences explain that other information can be obtained from psychological testing, such as information from the specialist's observations about the individual's ability to do the test.

Final 12.00D5c is the same as the sixth paragraph of proposed 12.00D except for minor editorial changes. It provides technical information about the salient characteristics of a good test. The section also reminds adjudicators about the need to note and resolve any discrepancies between formal test results and the individual's customary behavior and daily activities.

Final 12.00D6, ''Intelligence tests,'' consists of five paragraphs, designated 12.00D6a through 12.00D6e. These paragraphs incorporate various provisions from the fifth, eighth through eleventh, fifteenth, and sixteenth paragraphs of the proposed rules. These provisions of the proposed rules specifically concerned intelligence testing and properly should have been grouped together. In the course of reorganizing the provisions, we also revised them to simplify and clarify the rules.

We made several substantive changes throughout 12.00D6 in response to comments. We address the substantive changes in the public comments section of this preamble.

In 12.00D6d we made some technical changes. First, we added an introductory sentence which indicates that it is usually preferable to use IQ measures that are wide in scope and test both verbal and performance abilities. Then, we deleted the word ''nonverbal,'' which had been in the eighth paragraph of the proposed rules, and also deleted the reference to ''the Raven Progressive Matrices'' and added a reference to the ''Test of Nonverbal Intelligence, Third Edition (TONI–3).''

In addition, in final 12.00D6e, we made technical changes from the proposed rules. The final paragraph combines provisions from the fifteenth and sixteenth paragraphs of proposed 12.00D. These paragraphs discussed exceptions to formal standardized psychological testing and contained language that we copied from the fifteenth and sixteenth paragraphs of 112.00D in the childhood mental listings. In reviewing the sixteenth paragraph, we noted technical inaccuracies that had to be corrected. In the proposed rules, we referred to the ''Scale of Multi-Cultural Pluralistic Assessment (SOMPA),'' and called it a ''culture-free'' test. A more appropriate term is ''culture-fair.'' The SOMPA, however, is a test for children age 5 to 11 years 11 months old; therefore, reference to it is not appropriate in the adult rules. Moreover, the SOMPA battery of tests includes an age-appropriate Wechsler scale of intelligence. Since the Wechsler scales are English-language tests, they are not culture-fair. As such, their inclusion as part of the SOMPA makes that battery of tests not culture-fair, and therefore inappropriate for inclusion in the sixteenth paragraph of 112.00D of the childhood rules.

Also, the proposed sixteenth paragraph did not convey our intended meaning. The provision that required testing in an individual's principal language would have inadvertently ruled out consideration of the results of testing not done in the individual's principal language that happened to be part of the existing medical evidence. It also would have ruled out the possibility of testing a bilingual

individual in English, even if the individual has sufficient fluency in English as a second language. Further, the paragraph allowed for testing through a translator in some circumstances, even though this would introduce a variable that might compromise the results of the test. This was not our intent.

For all these reasons, we deleted the second through sixth sentences of the proposed sixteenth paragraph. Because the remaining paragraph was so similar to the proposed fifteenth paragraph, we combined the fifteenth and sixteenth paragraphs under one heading in final 12.00D6e. The paragraph addresses exceptions to formal standardized testing, including exceptions to standardized testing in the individual's own language. We still retain reference to the Leiter International Performance Scale-Revised and a discussion of individuals whose culture and background are not principally English-speaking in final 12.00D6d; therefore, there is no need to repeat the reference and discussion in final 12.00D6e.

Also, the fifteenth and sixteenth paragraphs of 112.00D of the childhood listings included some of the same wording that was problematic in the proposed adult rules. For this reason, and to maintain consistency between part A and part B, we replaced the fifteenth and sixteenth paragraphs in 112.00D with the same wording found in final 12.00D6d and 12.00D6e, revised slightly to make reference to children.

In final 12.00D7, ''Personality measures and projective testing techniques,'' we combined and simplified the provisions in the twelfth and fourteenth paragraphs of the proposed rules. The paragraph addresses standardized personality measures (such as the Minnesota Multiphasic Personality Inventory-Revised, or MMPI–II) and projective types of techniques (such as the Rorschach and Thematic Apperception Test, or TAT). For reasons we explain in the public comments section of this preamble, we deleted the proposed discussion devaluing these two types of tests. This deletion includes the discussion of the ''limited applicability'' of personality measures, and the statement that projective tests are not useful for program purposes. We now state that these tests may provide useful data for evaluating several types of mental disorders. In addition, we acknowledge that such test results may be useful for disability evaluation when corroborated by other evidence.

Final 12.00D8, ''Neuropsychological assessments,'' incorporates paragraphs seventeen through twenty of proposed 12.00D. We deleted the last two sentences of the proposed eighteenth paragraph of the NPRM in response to comments. In the last sentence of the first paragraph, which corresponds to the last sentence of the seventeenth paragraph of proposed 12.00D, we changed the word ''professionals'' to ''specialist,'' consistent with the terminology in final 12.00D5. We also deleted the phrase, ''and applying its findings in the disability decisionmaking process,'' because we have other regulations that address the qualifications of our medical and psychological consultants. We also reorganized and simplified the remaining provisions somewhat, but did not make substantive changes.

Final 12.00D9, ''Screening tests,'' corresponds to the thirteenth paragraph of proposed 12.00D. For reasons we explain in the public comments section of this preamble, we deleted the second and third sentences of the proposed paragraph. We also simplified the remaining language without making any substantive changes.

Final 12.00D10, 12.00D11, and 12.00D12 address three specific types of impairments. Final 12.00D10, ''Traumatic brain injury (TBI),'' corresponds to the twenty-second paragraph of proposed 12.00D. We expanded the statement we proposed, which referred only to the ''evaluation'' guidelines in 11.00F, to refer to the ''documentation and evaluation'' guidelines in 11.00F. We also made minor editorial changes, including a different heading for this paragraph. We describe our reason for making this change above, under the heading for 11.00F.

Final 12.00D11, ''Anxiety disorders,'' corresponds to the twenty-third paragraph of proposed 12.00D. The final and proposed paragraphs are nearly identical. We changed ''testimony'' to ''statements'' in the last sentence of the final paragraph.

Final 12.00D12, ''Eating disorders,'' corresponds to the twenty-fourth paragraph of proposed 12.00D. We made a technical clarification in the last sentence of the final paragraph. The sentence in the NPRM indicated that when the primary functional limitation is physical, any mental manifestations ''must'' also be considered in addition to the physical manifestations of the impairment. In the final paragraph, we added a clause to the end of the sentence providing an exception for the situation in which a fully favorable determination or decision is possible based on the physical findings alone. In such a case, we would not need to consider the individual's mental manifestations because we will have already found him or her disabled. Otherwise, there is no substantive change from the NPRM in the final paragraph.

Finally, we deleted four of the proposed paragraphs. We deleted the nineteenth and twentieth paragraphs because they addressed the evaluation of declines in cognition from premorbid functioning, a reference to the paragraph A7 criterion in listing 12.02. We are deferring adding these two paragraphs until we reassess the proposed changes to the A criteria of the listings. We deleted the seventh paragraph in response to a comment that pointed out that the paragraph could have been misinterpreted to preclude consideration of testing that did not demonstrate all of the salient characteristics of a ''good test.'' We deleted the twenty-first paragraph (which was also the ninth paragraph of prior 12.00D) because it could have been misleading in the context of the new rules. The paragraph explained that when the individual's cognitive impairment is such that standard intelligence testing is precluded, medical reports and observations by other individuals should be obtained to describe the individual's functioning. In fact, we may need this kind of evidence regardless of the type of impairment involved or whether intelligence testing is precluded. We did not want to give the impression that this was the only circumstance in which we would gather such evidence, and we have other rules that describe the various sources of evidence.

12.00E Chronic Mental Impairments

This section provides guidance and reminders for the evaluation of chronic mental disorders. Although the substance of the final rules is unchanged from the prior rules, we made minor editorial changes for clarity and comprehensiveness. We did not receive any comments about this section.

12.00F Effects of Structured Settings

Final 12.00F explains some of the factors we consider when an individual has overt symptomatology that is controlled or attenuated by psychosocial factors. We received two favorable comments and one suggestion about this provision, which we address in the public comments section of this preamble. The final rule is unchanged from the NPRM, except for minor editorial changes.

12.00G Effects of Medication

This section provides guidance about how we assess the effects of medication when we determine the functional limitations caused by an individual's mental impairment(s). In the final rules, we changed the terminology to reflect generic names for describing medications used in the treatment of mental disorders. As a result, we substituted the more common term ''drugs'' for ''psychoactive medications'' in the second and third sentences of the first paragraph and the first sentence of the second paragraph. Although the prior rules had used ''neuroleptics'' in the second paragraph, this specific class of drugs is subsumed under the broad term, ''drugs.''

12.00H Effects of Treatment

This section provides a reminder that treatment may have positive effects to the extent that an individual may not be disabled. Therefore, the paragraph includes a reminder that treatment ''may or may not'' enable an individual to work.

The final paragraph is substantively unchanged from the prior rules. In the NPRM, we proposed simplifying the paragraph and revising the parenthetical reference to include 12.02 and 12.04, which now also contain paragraph C criteria. In response to a comment about the fourth paragraph of proposed 12.00D, we also clarified the second sentence of the section to indicate that treatment may or may not assist in the achievement of an adequate level of adaptation required for ''sustained SGA'' instead of in the ''workplace.'' This is not a substantive change, only a clarification; we explain it more fully in the public comments section. We pluralized the word ''effect'' in the heading in the final rules for accuracy and consistency with the headings of the previous sections.

12.00I Technique for Reviewing Evidence in Mental Disorders Claims To Determine the Level of Impairment Severity

This brief section provides a cross-reference to §§ 404.1520a and 416.920a, which describe the technique that must be followed in claims involving mental impairments. Except for minor editorial simplification, the section is the same as in the NPRM, with minor editorial changes. We did not receive any comments about this section.

12.01 Category of Impairments, Mental

12.02 Organic Mental Disorders

In final listing 12.02, there are no changes in the paragraph A criteria from the prior rules, because we deferred making any of the changes we had proposed in the NPRM.

In the paragraph B criteria of listing 12.02, and all other listings that employ paragraph B criteria, we changed the paragraph B3 criterion (marked difficulties in maintaining concentration, persistence, or pace) to parallel the paragraph B1 and B2 criteria. In response to a comment that pointed to possible future misunderstandings, we simplified the criterion, for reasons we explain in the comments and responses section of this preamble. For consistency, we made similar changes in a number of places in 112.00.

We reworded final paragraph B4 to focus on decompensation. (The use of the word ''decomposition'' throughout the NPRM was a typographical error, although we did receive several comments about it.) As we explain under the heading for 12.00C, we defined the paragraph B4 criterion in the preface at 12.00C4. The paragraph B4 criterion now states, ''Repeated episodes of decompensation, each of extended duration.''

We added a new paragraph C to listing 12.02 to evaluate individuals with chronic organic mental disorders with symptoms or signs that are currently attenuated by medication or psychosocial support. These new provisions are similar to paragraph C of listing 12.03. The introductory paragraph of listing 12.02C reflects our longstanding policy as to what constitutes a ''severe'' impairment under §§ 404.1521, 416.921, 416.924, and Social Security Ruling 85–28. It also explains that a ''chronic'' mental disorder is one that has lasted for at least 2 years.

The opening sentence of paragraph C is substantively the same as in the NPRM, except for two minor editorial revisions. We revised paragraph C1, which in the proposed rules was identical to the paragraph B4 criterion, to reflect the changes in final paragraph B4. In response to a comment, we added a new paragraph C2 to address individuals who have a residual disease process and who do not suffer repeated episodes of decompensation, but who are so marginally adjusted that even a minimal increase in mental demands or a change in environment would be predicted to cause decompensation. As we explain in the public comments section, this is a longstanding policy interpretation that we intended paragraph C to cover.

Final paragraph C3, which was paragraph C2 in the NPRM, is unchanged, except for minor editorial changes. We based this revision on the prior listing 12.03C2 criterion describing a documented inability to function outside of a highly supportive living arrangement. We did not change the requirement from the proposed rules for a documented current history of an inability to function 1 or more years, in keeping with the statutory definition of disability, which requires that a disability must last for at least 12 months. The prior rules required a 2 year history.

All of the changes in final listing 12.02 were made in response to public comments. We provide detailed information about these changes, and our reasons for making them, in the public comments section of the preamble.

12.03 Schizophrenic, Paranoid and Other Psychotic Disorders

In the final rules, we revised the opening statement of final paragraph C to better reflect the nature of the disorders covered under listing 12.03. Final paragraphs C1, C2, and C3 are similar to those found in listing 12.02.

We received only one public comment about the proposed listing. Because it was a favorable comment and did not ask us to revise the proposed listing, we do not summarize it below.

12.04 Affective Disorders

Final listing 12.04 incorporates a new paragraph C, similar to the paragraph C criteria in listings 12.02 and 12.03. We revised the proposed paragraph B and C criteria consistent with the revisions to the paragraph B and C criteria we describe for listing 12.02.

We received only two comments about the proposed listing. One was complimentary and one offered a suggested addition to the paragraph A criteria of the listing.

12.05 Mental Retardation

In the final rules, we revised the heading of this listing to limit its scope to mental retardation.

In response to one comment, we expanded the phrase setting out the age limit for the ''developmental period.'' The final rules clarify that we do not necessarily require evidence from the developmental period to establish that the impairment began before the end of the developmental period. The final rules permit us to use judgment, based on current evidence, to infer when the impairment began. This is not a change in interpretation from the prior rules. We discuss this change in greater detail in the public comments section of this preamble.

In final listing 12.05C, as in the NPRM, we used the word ''an'' before the word ''additional'' to clarify that the additional impairment must be ''severe'' in order to establish ''an additional and significant work-related limitation of function.''

In the NPRM, we had removed the second clause of prior listing 12.05D, which referred to autism, and established a new listing 12.05E to evaluate autistic disorder and other pervasive developmental disorders. In response to a public comment and for consistency with the childhood mental disorders listings, we deleted proposed listing 12.05E from the final rules and established a new listing 12.10, ''Autistic disorder and other pervasive developmental disorders.'' Final listings 12.05 and 12.10 parallel the childhood mental disorders listings 112.05 and 112.10. We made this change to clarify the intent of proposed listing 12.05; the change does not disadvantage anyone. Those individuals diagnosed with both mental retardation and autistic disorder (or other pervasive developmental disorders) can be evaluated under either listing.

We also revised the paragraph B3 and B4 criteria in listing 12.05D to be consistent with the changes in listing 12.02. We summarize all of the comments, explain our responses, and describe the revised language in greater detail in the public comments section of this preamble.

12.06 Anxiety Related Disorders

In final listing 12.06, we made minor editorial changes and revisions to the paragraph B criteria, which we describe under the heading for listing 12.02.

12.07 Somatoform Disorders

In final listing 12.07, we deferred adding eating disorders and tic disorders as we had proposed in the NPRM.

As in the NPRM, the final listing requires that an impairment satisfy only two of the paragraph B criteria instead of three, as in the prior rules. However, we revised the paragraph B criteria in this listing, as we explain under the heading for listing 12.02.

12.08 Personality Disorders

In the final listing, we reduced to two the number of paragraph B criteria needed to meet the listing. There are no substantive differences between the final paragraph B criteria and the NPRM, other than the changes we explain under the heading for listing 12.02.

We did not receive any comments about listing 12.08 requiring a response. We received only favorable comments about our proposal to reduce the required number of paragraph B criteria from three to two.

12.10 Autistic Disorder and Other Pervasive Developmental Disorders

We established this new listing in response to a public comment about proposed listing 12.05. Final listing 12.10 parallels listing 112.10 under the childhood mental disorders listings.

Final listing 12.10 is met when the requirements in paragraphs A and B of the listing are satisfied. The paragraph B criteria, which we discuss under the heading for listing 12.02, are the same as those found in the other adult mental disorders listings.

112.00 Childhood Mental Disorders Listings

We made a number of changes throughout 112.00 to make the childhood mental disorders listings consistent with the final adult listings. In many cases, the revisions are not substantive. In others, our reasons for the changes are the same as our reasons for changing the adult rules, and we explain them above and in the public comments section of this preamble.

As we explain under the summary of final 12.00D6, we also revised the fifteenth and sixteenth paragraphs of 112.00D so that they are the same as final 12.00D6d and 12.00D6e, appropriately revised to refer to children. In addition, we revised the seventeenth paragraph of 112.00D; it is the same as 12.00D8.

Other Changes

In the NPRM, we had proposed to delete the last sentence in paragraph B of 5.00 (Digestive system) in connection with a change we had proposed to listing 12.07, ''Somatoform disorders.'' We did not receive any comments about this proposal, and, although we did not make the proposed change to listing 12.07, we deleted the sentence in these final rules.

In response to a comment about the definition of psychiatric signs in the third sentence of proposed 12.00B, we broadened and updated the sentence. Because the sentence in 12.00B was based on §§ 404.1528(b) and 416.928(b), we also revised those sections of the regulations and the corresponding sentence in 112.00B. The revisions are not substantive. We describe them in detail under the public comments about proposed 12.00B.

We revised the seventh paragraph of 112.00A to reflect the addition of paragraph C criteria to listings 12.02 and 12.04. We did not otherwise change the substance of the paragraph, however, because we still believe it is not necessary to include paragraph C criteria in the childhood listings.

We made a technical revision to the second sentence of the eighth paragraph of 112.00A to make it consistent with the revisions we made to the fourth paragraph of 12.00A.

In addition, we inserted a new third paragraph in 112.00C which explains that, even though the functional criteria for assessing limitations in children under age 3 are expressed in terms of chronological age, we will follow the rules in § 416.924a(b) when we evaluate the claims of infants and toddlers who are born prematurely. This technical change makes the discussion of how we assess impairment severity in claims involving mental disorders consistent with our other childhood disability rules.

We revised the second, fourth, and fifth sentences of the ninth paragraph of 112.00D so they are consistent with the changes we made in final 12.00D6c. We discuss all of these changes in the public comments section under 12.00D.

Finally, in addition to changes made in response to the comments and the technical changes described above, we made a number of nonsubstantive editorial changes throughout the final adult rules. For example, we changed some of the provisions from the passive voice to the active voice and revised punctuation and capitalization for consistency with our other rules. These revisions are only for clarity and consistency and do not change the meaning of the language we proposed.

Public Comments

After we published the NPRM in the **Federal Register** (56 FR 33130) on July 18, 1991, we mailed copies to national medical organizations and professionals whose responsibilities and interest require them to have some expertise in the evaluation of mental impairments. We also sent copies to Federal and State agencies (including the State agencies that make disability determinations for us) interested in the administration of the title II and title XVI disability programs. As part of our outreach efforts, we invited comments from mental health advocacy groups, as well as from legal service organizations.

We received over 120 letters containing comments pertaining to the changes we proposed. The majority of the comments were from psychologists, organizations and groups that represent people interested in specific mental impairments, and sources with specialized backgrounds in psychiatry. Many of the comments concerned the

specific diagnostic and severity rating criteria for the proposed listings, as well as our proposals to revise the discussion of psychological testing in the preface to these listings.

We carefully considered all of the comments and adopted many of the recommendations relevant to the proposed revisions finalized by these rules. We provide our reasons for adopting or not adopting the recommendations in the summary of the comments and our responses below. A few of the comments, however, pertained to Social Security matters that were not within the scope of the proposed regulations. We referred these comments to the appropriate components of the Social Security Administration and do not address them in this preamble.

Finally, a number of the comments were quite long and detailed. Of necessity, we have had to condense, summarize, or paraphrase them. Nevertheless, we have tried to present all views adequately and to respond to all of the relevant issues raised by the commenters.

Sections 404.1520a and 416.920a Evaluation of Mental Impairments

Comment: Many commenters expressed concern about the definitions for the terms for rating the degree of functional limitation (e.g., ''moderate,'' ''marked'') in proposed §§ 404.1520a(b)(3) and (b)(7) and 416.920a(b)(3) and (b)(7), which applied to adults and to children from age 3 to attainment of age 18. One commenter asserted that in attempting to clarify the rating scale points, we had focused on a specific range of mental illnesses and lost sight of the need to evaluate mental impairments on a longitudinal basis. As a result, the commenter believed that the proposed definitions only contemplated illnesses that remained constant and failed to consider episodic illnesses.

Several commenters, referring specifically to the proposed definitions of ''marked'' limitations, were concerned that the proposed rules did not recognize an important principle set out in the opening paragraph of 12.00C. That paragraph explains that a ''marked'' limitation may arise when several activities or functions are impaired, or even when only one is impaired, as long as the degree of limitation is such as to interfere seriously with the ability to function independently, appropriately, effectively, and on a sustained basis.

Response: We adopted the comments insofar as they relate to the revisions included in these final rules. As noted in the explanation of the final rules above, we substantially revised proposed §§ 404.1520a and 416.920a.

One substantive change we made in response to the comments was to delete the proposed scale point definitions and examples from the final rules. Instead, we included new language in final §§ 404.1520a(c)(1) and 416.920a(c)(1), expanded final §§ 404.1520a(c)(2) and 416.920a(c)(2), and modified the discussion in §§ 404.1520a(c)(4) and 416.920a(c)(4) regarding the last two scale points, ''marked'' and ''extreme.'' We discuss this latter change, and our reasons for it, later in this response.

We recognize that we consider many factors when we assess an individual's functioning. In final §§ 404.1520a(c)(1) and 416.920a(c)(1), we expanded the general guidance we had proposed in §§ 404.1520a(b)(1) and 416.920a(b)(1). The final rules clarify that we will consider the overall functional effects of an individual's impairment(s) longitudinally; i.e., over time. We also explain in the opening sentence of final §§ 404.1520a(c)(1) and 416.920a(c)(1) that the assessment of functional limitations is a complex and highly individualized process that requires us to consider multiple issues and all relevant evidence. In the second sentence, we provide examples of some of the factors that may affect an individual's functioning.

We reinforce these principles in final §§ 404.1520a(c)(2) and 416.920a(c)(2). Our intent in these paragraphs is to explain that the basic consideration in assessing functional limitations is the extent to which an individual's impairment or combination of impairments interferes with his or her ability to function independently, appropriately, effectively, and on a sustained basis. To reinforce the principle that this assessment is not tied to a particular number of limited activities, and to address the comments we received, we explain that among the factors we will consider is the quality and level of an individual's overall functional performance. We also include an explicit reference to limitations resulting from episodic illness. Finally, to recognize that there are other factors we will consider, we provide a cross-reference to several paragraphs in the adult mental disorders listings which describe these factors in more detail.

Given all the factors that we consider in rating the degree of functional limitations resulting from an impairment(s), we concluded that the rating scale definitions we had proposed were over simplified. As a result, we deleted them from these final rules. However, we retained and modified the last sentence of proposed §§ 404.1520a(b)(2) and (b)(4)(iii) and 416.920a(b)(2) and (b)(4)(iii). This sentence had stated that the last two points on each scale represent a degree of limitation that is incompatible with the ability to perform the work-related function or (for a child) to perform the function in an age-appropriate manner. The last sentence of final §§ 404.1520a(c)(4) and 416.920a(c)(4) now states that the ''extreme'' scale point represents a degree of limitation that is incompatible with the ability to do any gainful activity.

The final wording changes two things about the meaning of the sentence. First, it shifts the focus of the sentence from inability to perform particular work-related functions to inability to perform any gainful activity. The final rules reflect the listing-level severity standard in §§ 404.1525(a) and 416.925(a). This is a more severe standard of disability than is necessary to establish disability at the last steps of the sequential evaluation processes for adults. As a result, the final rules clarify that an ''extreme'' limitation in any one area of functioning means that the individual has an impairment(s) of listing-level severity.

Second, the final rules remove the implication that the next-to-last scale point, a ''marked'' limitation, can be equated with an ''extreme'' limitation. Since we shifted the focus of the sentence to listing-level severity, and because an individual must have ''marked'' limitations in two areas of functioning to be found to have a listing-level impairment, the revision clarifies the distinction between the ''marked'' and ''extreme'' degrees of limitation. At least one commenter thought this distinction was unclear in the proposed rules.

Comment: One commenter pointed out that in proposed §§ 404.1520a(b)(2) and 416.920a(b)(2), we stated that the four functional areas we use to evaluate the functional limitations of adults are ''essential'' to an adult's ability to work. The commenter asserted that, while each of these areas may have potential applicability to fitness for work, no empirical data exist to substantiate their utility in predicting performance on the job.

Response: We disagree, but accommodated the comment. The American Psychiatric Association, under contract to us, conducted an independent scientific assessment of the adult mental disorders listings which were revised in August 1985. The findings from the assessment, as reported in 1987, supported continued use of these four criteria when

predicting an individual's inability to do any gainful activity.

Nevertheless, we believe that the language proposed in §§ 404.1520a(b)(2) and 416.920a(b)(2) relating to the assessment of adult claims was more of an observation than a substantive rule and did not significantly add to the rules. Therefore, we deleted it from the final rules. We also clarified the third and fourth paragraphs of final 12.00A by replacing the word ''work'' with the phrase ''do any gainful activity.'' In addition, we deleted the word ''work'' from ''gainful work activity'' in the first sentence of the sixth paragraph. This will make it clear that the criteria in the listings establish listing-level severity, not just the inability to do any substantial gainful activity. (The references to ''work'' in the first paragraph of final 12.00A and elsewhere in the section are still correct in their particular contexts.)

Comment: One commenter recommended that we should continue to consider lay statements when assessing an individual's functional limitations under the revised rules in §§ 404.1520a and 416.920a.

Response: We did not intend to give the impression that we would stop considering such evidence. Current §§ 404.1513(e) and 416.913(e) acknowledge that information from lay sources may help us to understand how an individual's impairment(s) affects his or her ability to function. We believe that the extensive revisions to final §§ 404.1520a and 416.920a also make clear that we will consider all relevant evidence. These final rules do not change our policy regarding the use of lay statements in assessing the severity of mental impairments.

Comment: One commenter thought that the first sentence in proposed §§ 404.1520a(c)(3) and 416.920a(c)(3), regarding determinations of equivalence, was inconsistent with our policies on determining equivalence. The commenter said that the sentence indicated that the only consideration in determining equivalence was to be given to the listings themselves, and that this was ''a discredited notion.''

Response: The comment was unclear to us, but it indicated that some of the proposed rules had been misunderstood. For determinations of equivalence, we require our adjudicators to identify particular listed impairments to which an individual's impairment(s) is equivalent in severity. This does not mean that we require the individual to have an impairment cited in the listings, only that some justification must exist for a finding of equivalence. Thus, a comparison to a particular listing must demonstrate that an impairment(s) is equivalent in severity. Nevertheless, since this comment demonstrated that the language could be unclear, we replaced the proposed sentence with two introductory sentences, as we describe in the explanation of final §§ 404.1520a(d)(2) and 416.920a(d)(2).

We also replaced the potentially misleading phrase, ''equals the listings,'' in proposed §§ 404.1520a(c)(4) and 416.920a(c)(4) with the more accurate ''is equivalent in severity to any listing'' in final §§ 404.1520a(d)(3) and 416.920a(d)(3). In addition, we deleted the concluding phrase ''when appropriate to the category of claim being assessed'' from the sentence. All categories of cases involving a severe impairment(s) that neither meets nor is equivalent in severity to any listed impairment require an RFC assessment. Finally, we revised the first sentence of the sixth paragraph and the last sentence of the seventh paragraph of final 12.00A to use similar language to final §§ 404.1520a(d)(2) and 416.920a(d)(2).

Comment: One commenter asked whether the standard document, the ''Psychiatric Review Technique'' form (PRTF), will be revised to reflect changes in the listings.

Response: We have revised the original PRTF wherever necessary to reflect the revisions we made in the final rules for adults.

Comment: We received a number of comments about the change in proposed §§ 404.1520a(d)(1) and 416.920a(d)(1), which allowed the medical consultant or psychological consultant within the State agency to request disability examiners to assist in the completion of the PRTF. Two of the comments supported the change, noting that it would give State agencies additional flexibility in dealing with workload demands. However, most of the comments opposed the change.

Those who opposed the change gave at least one of the following reasons: (1) The proposal violated the Commissioner's (formerly the Secretary's) duty under section 221(h) of the Act to make every reasonable effort to ensure that the claims of individuals with mental impairments are evaluated by qualified psychiatrists or psychologists; (2) the proposal represented an arbitrary change in past agency policy; and (3) the proposal would lead to less accurate assessments at the State agency level, which would be detrimental to individuals with mental impairments. Most commenters opposed to the proposal recommended that we delete the proposed rule from the final rules.

Response: We did not adopt the comments that asked us to delete the proposed rule. In response to the comments, however, we clarified final §§ 404.1520a(e)(1) and 416.920a(e)(1).

The final rules now state more clearly that the medical or psychological consultant still has the overall responsibility for assessing the medical severity of the individual's mental impairment(s), even though a disability examiner may assist in preparing the PRTF. The medical or psychological consultant must review and sign the PRTF to attest that it is complete and that he or she is responsible for its content, including the findings of fact and any discussion of supporting evidence. The revision makes it clear that the change is consistent with sections 221(h) and 1614(a)(3)(H)(i) of the Act. These sections of the Act provide that we must make every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable RFC assessment in any initial determination in which there is evidence that an individual has a mental impairment, and in which we make a determination that the individual is not disabled. We assess medical severity as part of the medical portion of the case review. The initial preparation of all or part of a PRTF by a disability examiner assisting the physician or psychologist does not constitute part of the medical portion of the case review.

Allowing disability examiners to assist medical consultants or psychological consultants in preparing the PRTF does not change or dilute our statutory responsibility to make every reasonable effort to use medical or psychological consultants. The rules merely give the State agencies the option to utilize the training of their disability examiners so that they can use the expertise of their medical and psychological consultants as efficiently as possible. Disability examiners must be qualified to interpret and evaluate medical reports and other evidence relating to an individual's mental impairment(s). (See the paragraph following §§ 404.1615(c)(3) and 416.1015(c)(3).)

Moreover, the purpose of the statute was to ensure that in cases where there is evidence of a mental impairment, we would make every reasonable effort to have a qualified psychiatrist or psychologist complete the medical portion of the case review and any applicable RFC assessment before we make an initial determination that the

claimant is not disabled. Before Congress enacted sections 221(h) and 1614(a)(3)(H)(i) of the Act, there were no specific requirements in the statute or our regulations concerning the qualifications of medical consultants reviewing claims involving mental impairments. Rather, our regulations at that time simply stated that disability determinations were to be made by a State agency disability team that consisted of a medical consultant (a physician) and a disability examiner. Although the amendments require us to make every reasonable effort to have a qualified psychiatrist or psychologist complete the medical portion of the case review, they do not prohibit a disability examiner from assisting the medical or psychological consultant in the process.

These final rules authorize disability examiners to provide the same assistance in preparing the PRTF that they now provide to consultants in preparing RFC assessments. Disability examiners had been assisting State agency consultants in preparing individualized functional assessment forms in title XVI childhood cases since implementation of the SSI childhood disability rules on February 11, 1991 (56 FR 5534). Nothing in our experience indicates that this assistance had disadvantaged any children in the 6 years between publication of those rules and implementation of the new SSI childhood disability rules on February 11, 1997 (62 FR 6408). Disability examiners also have assisted medical and psychological consultants in preparing the childhood disability evaluation form since implementation of the new SSI childhood disability rules (§ 416.924(g)). Similarly, disability examiners have assisted medical and psychological consultants in preparing RFC forms since August 1, 1991, when we implemented final rules concerning ''Standards for Consultative Examinations and Existing Medical Evidence'' (56 FR 36932). In both processes, disability examiners have demonstrated their ability to provide valuable assistance, and we believe their expertise will be of similar benefit to the PRTF process. Based on our experience, and our confidence in the qualifications of the State agency disability examiners, we do not believe that individuals will be disadvantaged by allowing State agencies the option of having disability examiners assume similar responsibilities in preparing the PRTF, since the medical or psychological consultant retains overall responsibility for assessing the medical severity of an individual's mental impairment.

Comment: One commenter stated that proposed §§ 404.1520a(d)(1) and 416.920a(d)(1) were internally inconsistent because each paragraph began with a sentence requiring the medical or psychological consultant to perform the evaluation and complete the standard document, yet in a later sentence allowed the disability examiner to complete the entire document and only required the consultant to sign it. In addition, this commenter opined that since §§ 404.1512(b)(6) and 416.912(b)(6) state that the findings of State agency medical and psychological consultants are considered ''medical evidence'' at the administrative law judge and Appeals Council levels, disability examiner involvement in completing the PRTF either should be precluded or identified in some fashion, since those recorded findings would not constitute ''medical evidence.''

Response: We clarified final §§ 404.1520a(e)(1) and 416.920a(e)(1) in response to the first part of the comment. We agree that the proposed rules used the phrase ''complete the standard document'' ambiguously to mean ''fill out'' the form in some instances and ''finalize'' (as by signature) in others. The final rules remove this ambiguity.

We do not agree with the commenter's second argument. When the medical or psychological consultant signs the PRTF, his or her signature attests that it is complete and that its entire content represents his or her medical findings. Any entries made by a disability examiner on the PRTF become the findings of the medical or psychological consultant when he or she attests to its completeness and its content by signing the form. Accordingly, the administrative law judge or the Appeals Council (when the Appeals Council issues a decision) will still evaluate these findings using our existing rules (§§ 404.1527(f)(2) and (f)(3), 416.927(f)(2) and (f)(3), and SSR 96–6p).

Comment: A few commenters questioned our proposal in §§ 404.1520a(d) and 416.920a(d) of the NPRM (final §§ 404.1520a(e) and 416.920a(e)) to eliminate the use of the PRTF at the administrative law judge hearing and Appeals Council levels of the administrative review process. One commenter noted that the proposed sections appeared to direct administrative law judges to incorporate in their written decisions the same information used on the PRTF. This commenter believed that the PRTF ought to satisfy the documentation requirements. The commenter suggested that we revise the section to allow administrative law judges the option of using the PRTF, either in the decision or as an attachment to it. Another commenter indicated that some administrative law judges may find the PRTF a useful checklist and recommended that they be given the discretion to use the form and append it to their decisions. Since only decisions that are likely to undergo further administrative or judicial review are at issue, one commenter suggested requiring the PRTF at least for those decisions.

A few commenters believed that the PRTF has helped to ensure the quality and completeness of hearing decisions, that it is a safeguard against incomplete review of the evidence, and that it assures claimants and advocates that the decision conforms strictly to our rules for evaluating mental impairments.

Response: We did not adopt the comments. The primary purpose of the final rules is to describe the technique, as distinct from the form, and to require the use of the technique in all determinations and decisions at all levels of the administrative review process, including the hearings and appeals levels. The technique is a systematic process adjudicators apply when evaluating an individual's mental impairment(s). The PRTF (i.e., the form itself) should not be confused with application of the technique; the form simply documents application of the technique with a checklist of our conclusions.

When we first promulgated these rules in 1985, we believed that they were so novel and complex that it would be useful to require all adjudicators at all levels of the administrative review process to complete the PRTF. At the initial and reconsideration levels, the PRTF has proven to be a simple and convenient method of documenting the conclusions reached by our medical and psychological consultants when applying the technique.

Even though we apply the same technique at the administrative law judge hearing and Appeals Council levels as we do at the initial and reconsideration levels, administrative law judge and Appeals Council decisions are quite different in form from determinations prepared by a State agency. Administrative law judge and Appeals Council decisions include a more detailed explanation of the findings and conclusions reached, supported by a narrative rationale. The decisions under these final rules must include, among other things, the pertinent findings and conclusions required in the application of the technique. Consequently, requiring that a PRTF be appended to an

administrative law judge or Appeals Council decision would only repeat information already required in the decision under these final rules, and renders the PRTF redundant. For this reason, these final rules do not require administrative law judges or the Appeals Council to complete the form or to attach the form to their decisions, just as we do not require them to complete or attach RFC assessment forms to their decisions.

We recognize that administrative law judges and members of the Appeals Council may find the PRTF useful as a checklist and for organizing information in the record. These final rules do not prohibit the use of the form at the hearings and appeals levels to assist the decisionmaker in applying the technique and issuing a decision.

Comment: A few commenters objected to our proposal to delete the special administrative law judge remand provision of prior §§ 404.1520a(d)(1)(iii) and 416.920a(d)(1)(iii). Most of these commenters thought that we should retain a provision giving administrative law judges the option to remand cases to the State agencies when new evidence is received at the hearing level that is not merely cumulative of evidence already in the case file, or when the issue of a mental impairment first arises at the hearing level.

Two of these commenters, in identical language, said that the omission of the prior remand provision would make it ''less likely that an administrative law judge would consider new evidence at all.'' The same two commenters thought that the deletion of the prior provision left it unclear whether administrative law judges would be required to evaluate the new evidence without the assistance of the State agency. Another commenter said that the deletion of the provision would result in the issuance of more decisions without fully developed evidence and cause more remands by the Appeals Council and the Federal courts.

One commenter suggested that we strengthen the prior provision instead of deleting it. The commenter provided language for the rules that would require administrative law judges to remand cases in most instances in which new evidence at the hearing level raised the issue of a mental impairment for the first time. Conversely, one commenter thought that proposed §§ 404.1520a(d)(3) and 416.920a(d)(3), which provided for remand to the State agency for completion of the standard document only when an administrative law judge was unable to obtain the services of a medical expert, was too broad. The commenter believed that returning a case to the State agency for completion of the standard document is very time-consuming and could result in nothing more than a second reconsideration. The commenter suggested that we revise our regulations to prevent this.

Two commenters thought the reference to §§ 404.948(c) and 416.1448(c) in proposed paragraph (d)(3) was not a substitute for the deleted provision. One of these commenters challenged the statement in the preamble of the proposed rules (56 FR at 33131) which said that the former administrative law judge remand provision could be deleted because it covers ''what is already covered in §§ 404.941, 404.948, 416.1441, and 416.1448.'' This commenter stated that §§ 404.948 and 416.1448 discuss issuing decisions that are fully favorable to the claimant without an oral hearing and have no relevance to the issue of evidence of a mental impairment first being submitted at the hearing level. The commenter also noted that §§ 404.941 and 416.1441, which discuss prehearing case reviews, are pertinent only when additional evidence is submitted before a scheduled hearing, so sufficient time remains to conduct the review and decide how to address the issues involved.

Response: We understand the commenter's concerns. However, in light of our experience, we do not believe that the prior rules allowed more flexibility and efficiency in resolving claims. Further, the former provisions went beyond their intended scope; i.e., how an administrative law judge can get assistance in applying the technique when the services of a medical expert are needed but unavailable. Although we did not adopt the comments, we clarified final §§ 404.1520a(e)(3) and 416.920a(e)(3).

We agree with the commenter who observed that the provisions in §§ 404.941, 404.948, 416.1441, and 416.1448 are somewhat different from those in §§ 404.1520a(d)(1)(iii) and 416.920a(d)(1)(iii) of the prior rules. All discuss the administrative law judge's return of a case to the State agency for further consideration. The return of a case to the State agency for a prehearing case review, which is described in §§ 404.941 and 416.1441, does not delay the scheduling of a hearing. Under this provision, we may return the case to the State agency before the hearing is held, when there is reason to believe that a revised determination wholly or partially favorable to the individual may result. The State agency can then decide whether or not to revise its prior determination. The prehearing case review will not delay the scheduled hearing unless the individual agrees. Similarly, the administrative law judge remand procedure described in §§ 404.948(c) and 416.1448(c) is also designed for speedy claim resolution. It allows an administrative law judge to return a case to the State agency for a revised determination without an oral hearing when there is reason to believe the revised determination would be fully favorable to the individual. In such a case, the individual is notified of the remand and afforded the opportunity to object to it.

In contrast, under the special remand provision in §§ 404.1520a(d)(1)(iii) and 416.920a(d)(1)(iii) of the prior rules, in certain instances an administrative law judge could remand a case involving a mental impairment to the State agency for completion of the standard document and a revised determination. The revised determination the State agency could issue upon remand could be unfavorable to the individual and the individual would be required to request another hearing if he or she wished to pursue his or her claim. Ironically, when we proposed the special remand provision in former §§ 404.1520a(d)(1)(iii) and 416.920a(d)(1)(iii) in 1985, most commenters opposed it, primarily because they were concerned that it would cause undue delay in our decisionmaking (50 FR at 35047).

In fact, we did not intend for the scope of the prior rules to go beyond the established rules in §§ 404.941, 404.948, 416.1441, and 416.1448, although such an interpretation of the prior rules was possible. Our response to comments to the final rules published in 1985 shows that we intended the prior sections to be applied within the context of our rules on prehearing case reviews and decisions without oral hearings, and that it not delay the decisionmaking process. We responded: ''We believe the remand procedure is consistent with current practice at the hearings level'' and ''[b]ased upon our past experience with the need to remand cases, undue delay should not occur in the disability decision-making process.'' (50 FR at 35047.) Thus, we did not intend to expand the remand procedures in 1985. All we have done in final §§ 404.1520a(e)(3) and 416.920a(e)(3), is to make clear our original intent to provide the least time-consuming means of issuing a favorable decision.

We strongly disagree with the comments that suggested the deletion of the former administrative law judge remand provision from these final rules will result in mental impairment issues first raised at the hearing level being

ignored, inadequately developed, or not fully analyzed by administrative law judges. Nor do we agree that this provision will result in more remands at the Appeals Council and Federal court levels. We believe that our existing rules make it clear that all adjudicators, including administrative law judges, are required to consider all relevant evidence and to develop the record fully.

While it is more efficient for an individual to submit evidence relating to a new issue at the time he or she files a request for hearing, or at least prior to a scheduled hearing, we recognize that this does not always occur. Sections 404.936, 404.944, 416.1436, and 416.1444 provide that an administrative law judge may adjourn, postpone, or reopen the hearing at any time before notice of the decision is released in order to receive or obtain new and material evidence. Presented with insufficient evidence to determine the nature and severity of an individual's mental impairment(s), an administrative law judge must follow our existing rules and seek additional evidence from appropriate sources, regardless of whether we were aware of the mental impairment(s) at the time the initial and reconsideration determinations were issued.

Finally, we disagree with the comment indicating that returning the case to the State agency for completion of a PRTF will result in nothing more than a second reconsidered determination and unnecessary delays. We believe the procedures in these rules are no more time-consuming than the former rules, and in some cases may actually save time. Nevertheless, we have clarified final §§ 404.1520a(e)(3) and 416.920a(e)(3) by deleting the reference to the remand provisions in §§ 404.948(c) and 416.1448(c), and avoiding the use of the word ''remand'' since it may imply that the administrative law judge is requesting a revised determination in every case. The final rules indicate that the State agency will issue a revised determination if a decision favorable to the claimant is warranted based on a review of the case file, so as not to delay the payment of benefits. Otherwise, the State agency will return the case, with a completed PRTF, to the administrative law judge, who will proceed with a hearing and issue a decision.

11.00F Traumatic Brain Injury (TBI)

Comment: Several commenters addressed the proposed rules in 11.00F that required deferral of determinations of disability for up to 6 months in cases of TBI unless a favorable determination could be made sooner. Some were pleased with the proposal. One commenter recommended that we revise the proposed rules to ensure that all TBI cases are not placed in the deferred adjudication categories. Another asked if we would add a provision to deny TBI cases at 3 months or earlier if there is no allegation or medical evidence of an impairment that is more than ''not severe.'' Four commenters suggested that we find individuals whose cases we defer to be presumptively eligible for disability payments, thus giving them access to health care under Medicaid and other services for which they might be eligible.

Response: We did not adopt the comments that asked us to change the proposed rules or provide presumptive disability payments to people with TBI. We intentionally required evidence at least 6 months post-injury before we can deny a TBI claim, even when the individual's allegation or the immediate posttraumatic medical evidence suggests the impairment is ''not severe.'' We decided to allow for the deferral of adjudication of such cases because of the variability and uncertainty of recovery from TBI. We believe the initial 3-month period for deferral (when the individual does not have a profound neurological impairment permitting an earlier finding of disability) and, if necessary, an additional 3-month period, will allow sufficient time for the impairment(s) to stabilize so we can make an accurate projection regarding its severity and duration.

The rule in 11.00F, however, does not prevent us from finding disability sooner on the basis of some other impairment. For example, if an individual has a serious accident with multiple injuries including TBI, the nature and expected course of the additional impairment(s) may support a finding of disability within 3 months post-injury, regardless of any impairment(s) resulting from the brain injury.

Finally, we did not adopt the suggestion to make individuals with TBI presumptively eligible for disability payments while adjudication of their cases is being deferred. Presumptive disability payments are authorized only under title XVI, the SSI program, and would not apply to individuals who file claims only under title II. The rules for presumptive disability in the SSI program are set out in §§ 416.931 through 416.934.

We are not amending these rules to reflect this comment. As we explain in § 416.933, we may make a finding of presumptive disability when the evidence reflects a ''high degree of probability'' that an individual is disabled. The reason we will defer some determinations in TBI cases, however, is that it is not clear whether the individuals are disabled because of the variable and uncertain nature of their impairments. Thus, the evidence does not reflect the requisite degree of probability of disability for presumptive eligibility under our rules. The commenter's suggestion that providing Medicaid and other medical resources to individuals with TBI may be more cost-effective in the long run may be sound, but we have decided that in this instance claimants will not have presented evidence demonstrating a high degree of probability that they are disabled.

Comment: One national organization submitted technical medical comments about TBI and our proposed rules that it had solicited from several professionals. One of the comments included a statement that our disability evaluation criteria poorly served individuals with TBI and a recommendation that we restructure the criteria so that TBI ''patients do not fall through the cracks.''

Response: Many of the comments submitted by the organization related to the current neurological listings, rather than the proposed revisions to the mental listings. Accordingly, those comments are outside the scope of this rulemaking proceeding. We are in the process of reviewing the neurological listings criteria and will consider these comments as part of that process.

Some of the comments addressed the prior mental disorders listings, and we address most of those comments below. A few were comments about criteria in the prior mental listings that we had already proposed to change in the NPRM, some in ways very similar to those suggested in the comments. We did not summarize those comments below because the proposed rules had already addressed their concerns.

We share the commenter's concern about individuals with TBI. As a result, we proposed the new 11.00F in the preface to the neurological listings, which includes rules that are unusual in our program because they provide for the deferral of adjudication of such claims, even when it appears that the individual may not have a significant impairment. Furthermore, we added a paragraph to the preface of the mental disorders listings that provides a cross-reference to the new guidance in 11.00F. This cross-reference reminds adjudicators that cases of TBI can be more complex and may involve both mental and physical impairments. We

believe that these provisions of the final rules will help ensure that individuals with TBI ''do not fall through the cracks.''

Although we do not have a comprehensive list of all the various neurological and mental impairments that can be associated with TBI, we believe that the possible manifestations of TBI are covered in various listings in 11.00 (the neurological listings) and 12.00 (mental disorders). Indeed, other comments submitted by the organization seemed to agree with this conclusion. However, as we have said, we will also consider the comments about our current neurological listings as we review those listings. Finally, in response to this comment, we revised the heading of final 11.00F from the proposed ''Cerebral trauma'' to ''Traumatic brain injury (TBI)'' to make the subject of the section clearer.

Comment: One commenter noted that listing 12.02, ''Organic mental disorders,'' applies to individuals with TBI but suggested that we include some types of affective disorders and mood aberrations in the listing. The commenter was aware that listing 12.04 expressly covers mood disorders, but was concerned that it would not apply to people with TBI.

Response: We did not adopt the comment because listing 12.02A5, ''Disturbance in mood,'' already includes mood disturbances in the listing for organic mental disorders. In addition, even though listing 11.18 does not refer to listing 12.04 for evaluating an individual with cerebral trauma, we can use listing 12.04 to evaluate a claim involving TBI if the individual has a medically determinable mood disorder.

Comment: An individual submitted several comments, a complete clinical reference text, and chapter abstracts from a draft book on numerous aspects of TBI and related neuropsychological impairments. Some comments referred to proposed 11.00F, while others referred to other parts of the proposed rules as they relate to TBI. In general, the commenter approved of the separate discussion of TBI in proposed 11.00F, including our recognition of the fact that symptoms evolve over time. However, the commenter believed that the DSM–III–R, upon which the diagnostic criteria in proposed listing 12.02 were based, did not capture the full range of psychopathology associated with TBI. The commenter found the term ''organic mental disorders'' vague, overly inclusive, and archaic. The commenter recommended that the listing specify the etiology of the trauma and the range of dysfunctions as determined by modern neuropsychological research and clinical experience.

Response: We thank this commenter for the favorable comments and for all the reference materials, which present an excellent discussion of many of the problems associated with evaluating TBI. Our goal in proposed 11.00F was to provide additional guidance to address these problems, and we appreciate that the commenter finds the paragraph helpful. With respect to the diagnostic criteria found in listing 12.02, however, we do not share this commenter's view of the DSM–III–R. Nor do we believe that this mental disorder listing, or any other, needs to refer specifically to etiology or to the entire range of symptoms determined by research and clinical experience.

As we explained in the preambles to these rules when they were proposed (56 FR at 33130) and the final rules revising the childhood mental disorders listings (55 FR at 51214, 51215), we used the DSM–III–R as the basis for the diagnostic criteria in our mental disorders listings because this reference manual is widely used and accepted in the psychiatric and psychological communities. We believe the common understanding it provides makes it the most useful resource for these listings. We recognize that some clinicians may prefer greater diagnostic specificity than that found in the DSM–III–R (or DSM–IV) or these listings. Nevertheless, as we also explained in the preambles, the diagnostic criteria in the mental disorders listings are not bound by those in the DSM–III–R (or DSM–IV), nor was it our purpose to include every mental impairment or every symptom or sign of the disorders that are listed. The focus of our disability programs is to determine the extent of the functional limitations imposed by a medically determinable impairment(s). Hence, instead of attempting to catalogue every possible mental impairment, these listings provide examples of some of the impairments we consider severe enough to be disabling under our program requirements. We do not discount impairments that are not listed; we evaluate them using our rules for equivalence.

In selecting the diagnostic criteria for these listings, we employ an atheoretical approach with regard to etiology, primarily because our program focus is on functional limitations, and etiology is therefore of less significance to us. Also, we believe it would be very difficult, if not impossible, to obtain evidence relating to the pathophysiologic processes of all the mental disorders we evaluate. Further, we recognize that etiology may be a controversial area for some mental disorders. Thus, its introduction into our criteria might prove to be an obstacle to clinicians of varying theoretical orientations.

Comment: The same commenter believed that professionals who make disability determinations should be aware of the mechanism of brain trauma, its pathophysiological and pathoanatomical effects, and the proper documentation (within the scope of their own professions) of neurobehavioral impairment and the emotional effects of accidents and of being impaired. The commenter recommended that we establish specialty qualifications for these professionals, such as special neuropsychological training or certification as a Diplomate in Clinical Neuropsychology for psychologists.

Response: We agree that the professionals who make our disability determinations should be properly trained to evaluate all types of impairments. This includes TBI, with all the factors the commenter described. We disagree, however, that we need additional qualifications for these professionals. Our current qualification standards for medical and psychological consultants are outlined in §§ 404.1616 and 416.1016. We do not believe it necessary or practicable to establish more stringent standards for those who would evaluate one type of impairment. To do so would restrict the pool of qualified specialists available to State agencies.

Nevertheless, we recognize that TBI cases can be difficult to evaluate. That is one reason we included 11.00F in these rules. We have issued guidance for evaluating these cases in the past, and we will issue internal operating guidelines and training material to supplement the information in final 11.00F to ensure that all professionals who evaluate cases involving TBI have the latest information. We also will provide additional guidance to any State agencies requesting clarification of specific issues.

Comment: The same commenter stated that TBI is ''best documented through a wide range examination, including a thorough interview.'' The commenter pointed out that using single tests in isolation, without baseline evidence, is below the standards of acceptable practice because test results must be considered in the context of the interview, the individual's IQ, and his or her educational and vocational background. The commenter also provided detailed information about the kinds of evidence that would be necessary to establish a thorough record

in TBI cases and standards for establishing the validity of testing. The commenter encouraged the use of documentation supplied by health care providers.

Response: We agree that TBI is best documented by a comprehensive examination which includes a thorough interview. We also agree that considering single tests in isolation is inappropriate and that all test results must be considered in the context of all other evidence to establish a complete picture of the individual's impairment and level of functioning.

We also agree that tests should have suitable psychometric standards and should be supplemented by useful qualitative procedures. For this reason, when we proposed revisions to the mental disorders listings, we incorporated existing operating instructions regarding the salient characteristics of a good test into the sixth paragraph of proposed 12.00D. This paragraph, final 12.00D5c, concludes with a sentence which states: ''In considering the validity of a test result, we should note and resolve any discrepancies between formal test results and the individual's customary behavior and daily activities.''

Comment: The same commenter expressed concern about the evaluation of children with TBI. He noted that an undeveloped and thus resistive or disorganized child may not be able to take a conventional psychological examination, and this inability to be tested may itself be a sign of dysfunction.

Response: We agree with this commenter's observations. One very important policy principle in our rules, which we follow in both childhood and adult claims, is that the evaluation of evidence should result in an assessment of the individual's functioning on a longitudinal basis. We recognize that single examinations and tests may or may not accurately reflect an individual's ability to function in normal settings. This policy principle is reflected in 112.00D of the childhood mental listings, as well as in our rules for evaluating disability in children under title XVI, beginning at § 416.924.

12.00 Mental Disorders

12.00B Need for Medical Evidence

Comment: One commenter suggested that we expand the definition of psychiatric signs in the third sentence of proposed 12.00B to include reference to specific abnormalities of ''attention'' and ''perception.''

Response: We partially adopted the comment. We modified the sentence in final 12.00B to indicate that the specific abnormalities cited are examples, not an all-inclusive list, and we revised the examples in the section. In response to the comment, we changed the example of contact with reality to an example of abnormality of perception.

In selecting examples of psychological abnormalities to include in the final definition of psychiatric signs, we did not add ''abnormalities of attention'' because it is covered by ''abnormalities of behavior.'' However, we substituted the suggested ''abnormalities of perception'' for our prior reference to ''abnormalities of contact with reality'' because ''abnormalities of perception'' is a more specific example. We also changed ''abnormalities of affect'' to ''abnormalities of mood'' to reflect current diagnostic nomenclature. We added abnormalities in ''development'' to the list because some psychological abnormalities are first evident in childhood and continue into adulthood.

The third sentence of 12.00B was an exact restatement of the third sentence of §§ 404.1528(b) and 416.928(b), the regulations that define the term ''signs,'' and was also repeated in 112.00B of the childhood mental listings. Therefore, to reflect the changes in final 12.00B, we made similar modifications to the definition of psychiatric signs in those sections.

Comment: One commenter was concerned that we cited psychiatrists and psychologists as the only examples of appropriate medical sources in the third sentence of proposed 12.00B. The commenter said that many medical personnel, such as nurses, social workers, and physicians' assistants, are qualified to recognize signs of mental impairment. Another commenter suggested that we include physiatrists and neurologists in the list of examples.

Response: We accommodated the comments. We agree that no relevant source of evidence should be overlooked when developing claims involving mental impairments. Our intent in providing the two specific examples of appropriate medical sources in proposed 12.00B was not to diminish the value of evidence provided by other sources, but to identify which of the acceptable medical sources cited in §§ 404.1513(a) and 416.913(a) usually provide evidence in claims involving mental impairments. While we could have cited other physicians, such as physiatrists and neurologists, in this list of examples, we would not have included nurses, social workers, and physicians' assistants in the list. The latter are defined as ''other sources'' of evidence in §§ 404.1513(e) and 416.913(e) and are not ''acceptable medical sources'' who can provide evidence to establish the existence of a medically determinable mental impairment. Such sources can, however, provide very valuable information about the severity of an impairment(s) once the existence of such an impairment has been established with evidence from an ''acceptable medical source.''

As a result of these two comments, we again looked at the need to provide specific examples of appropriate medical sources in 12.00B. Since the purpose of this section of the preface to the listings is to discuss the need for medical evidence and not who can supply it, we decided it was unnecessary to provide any examples and deleted those we had proposed from the third sentence of final 12.00B.

12.00C Assessment of Severity

Comment: We received five comments about our proposal to change the example of a marked limitation in activities of daily living in the second paragraph of proposed 12.00C1. All of the commenters asked us to retain the prior example of an individual who is able to cook and clean but is too fearful to leave the immediate environment of home and neighborhood, saying that it was still useful and appropriate. In addition, most did not object to our retaining the proposed example of an individual who cannot perform a ''wide range of daily activities * * * independently.'' However, one commenter thought that the proposed example was too imprecise to be useful.

Response: We did not adopt the comments asking us to restore the prior example, but we have replaced the example in the second paragraph of final 12.00C1 with more descriptive text in response to the last comment.

We did not reinstate the example from the prior rules because it describes a person with agoraphobia. We agree with the commenters that it is still an appropriate example of a marked limitation in activities of daily living. Nonetheless, we deleted it because we were concerned that, as the sole example, its specificity could result in too narrow an interpretation of what constitutes a marked limitation in this area.

We agree with the last commenter that the example we proposed required too many factual assumptions about what constituted independence and a ''wide range of daily activities'' to be helpful. Therefore, in the final rules, we replaced the proposed example with a sentence describing some of the considerations for assessing limitations in activities of daily living. We believe that this descriptive approach will be

more helpful than any example providing a single, narrow fact pattern.

Comment: One commenter suggested that the discussion of task completion in proposed 12.00C3 should also address the quality and accuracy of the tasks being completed, as well as their timeliness.

Response: We adopted the comment. In the first sentence of the first paragraph of final 12.00C3, we inserted the words ''and appropriate'' between the words ''timely'' and ''completion.'' Thus, the final sentence defines concentration, persistence, or pace in terms of the individual's ability to sustain focused attention and concentration of sufficient length to permit the timely and appropriate completion of tasks commonly found in work settings.

We also added a new fifth paragraph to final 12.00C3 similar to the paragraphs in 12.00C1 and 12.00C2 that define the term ''marked'' by ''the nature and overall degree of interference with function.'' The new paragraph indicates that we may find a marked limitation in concentration, persistence, or pace even though the individual can complete many simple tasks if the impairment nonetheless interferes seriously with the individual's ability to complete those tasks in accordance with quality and accuracy standards. However, the provision also states that deficiencies in concentration, persistence, or pace that are apparent only in performing complex tasks would not necessarily satisfy the intent of the paragraph B3 criterion. An individual who is unable to do complex tasks, but who is able to do simple tasks independently, appropriately, and effectively, may or may not be disabled, and may not have a ''marked'' limitation in concentration, persistence, or pace.

Comment: Several comments addressed the proposal to reverse the order of the second and third sentences of prior 12.00C3 and to characterize the ability to complete household tasks as an ''example'' of a way to assess a person's ability to concentrate under this criterion. The commenters pointed out that individuals who cannot tolerate work stress may nevertheless be able to complete household tasks. Two commenters noted that the proposed example was illogical in context because it followed a sentence that explained that difficulties in task completion are best observed in ''work and work-like'' settings. The commenters believed that the household is not a work-like setting. One commenter thought that in the prior rules the reference to household routines made sense because it came before the statement about the observation of deficiencies in work or work-like situations, not after.

One commenter recommended that we delete the example. The commenter noted that the example did not address the fact that households can be highly structured and supportive environments and that it was silent about the need to evaluate the pace and timeliness of household chores, two factors that might indicate an inability to function at a competitive level.

Response: We adopted the comments, although we believe that it is important to consider an individual's activities in all settings to draw reasonable inferences about his or her abilities to tolerate stress in the workplace, especially because not all individuals have recent work histories. Thus, we consider the ability to complete tasks in other settings when we assess the degree of limitation the impairment(s) imposes in this functional domain.

Nevertheless, we agree with the commenters that the example could have been confusing following a sentence about ''work and work-like settings.'' We also agree that the ability to do household activities does not necessarily correlate with the ability to do work tasks. Therefore, we made a number of revisions in the final rules. First, we deleted the example of everyday household routines in the first paragraph of final 12.00C3, as suggested by the commenter. Second, we broadened and clarified the second sentence by deleting the reference to ''work-like'' settings and indicating that, while limitations in the ability to complete work tasks are best observed in work settings, such limitations may also be reflected by limitations ''in other settings.'' This will include ''work-like'' and household settings, but is not necessarily limited to such settings.

Third, we also believe that some type of cautionary language is needed in this portion of the preface. Thus, we added a new fourth paragraph to final 12.00C3 that reminds adjudicators to use great care when drawing inferences about an individual's ability to complete tasks in work settings based on his or her ability to complete tasks in other settings. This discussion notes, among other things, that other settings can be highly structured and supportive.

Comment: Several of the above commenters suggested that we provide examples of task completion related to work. Three of the commenters asked us to restore the examples of work tasks from the prior rules.

Response: We adopted the comments. We restored the examples of filing index cards, locating telephone numbers, and disassembling and reassembling objects in a parenthetical example at the end of the first sentence of the third paragraph of final 12.00C3.

Comment: One commenter recommended that we modify the beginning of the last sentence in the first paragraph of proposed 12.00C3, which referred to ''direct psychiatric examination,'' to acknowledge that psychologists perform clinical evaluations and mental status examinations as well as conduct psychological testing. In addition, the commenter suggested that we revise the latter part of this sentence to address situations in which, due to the nature of the individual's disorder or social isolation, additional evidence of the individual's ability to complete tasks cannot be obtained to supplement findings obtained during a mental status examination or psychological testing session.

Response: We adopted the comments and the substance of the suggested revisions. In using the word ''psychiatric,'' we did not intend to exclude psychologists who perform clinical examinations. Rather, we intended only to distinguish between psychiatric evaluations (such as formal mental status examinations) and psychological testing. This could have been inferred from the phrase ''mental status examination or psychological test data'' in the second clause of the sentence, but we agree that the proposed rules could have been clearer. To clarify the rules, we revised the third sentence of the first paragraph of final 12.00C3 to refer to ''clinical examination'' instead of ''direct psychiatric examination.'' The term ''clinical examination'' includes formal mental status examinations and other ''psychiatric'' examinations, as opposed to psychological testing. We did not expand the sentence to say ''direct psychological or psychiatric examination,'' as suggested by the commenter, because we believe that the phrase could be read to mean that psychologists and psychiatrists perform different kinds of clinical examinations, not that these examinations can be performed either by psychologists or psychiatrists, as we believe the commenter intended.

With regard to the second comment, we deleted the latter part of the proposed sentence, including the phrase ''alone should not be used,'' and added a new sentence. The fourth sentence of the first paragraph of final 12.00C3 explains that whenever possible, we will supplement a mental status examination or psychological test data with other available evidence. We also emphasized the point in the new fourth

paragraph of final 12.00C3, which stresses that the ability to complete tasks must be assessed by the evaluation of all the evidence.

Comment: Two commenters recommended that we revise the first sentence of the second paragraph of proposed 12.00C3 to acknowledge that serial threes, as well as serial sevens, are used for the assessment of concentration in some individuals.

Response: We adopted the comment.

Comment: One commenter suggested we include examples of specific psychological tests of intelligence and memory in the last sentence of the second paragraph of proposed 12.00C3.

Response: We did not adopt the comment. The purpose of this section of the preface to the listings is to discuss the assessment of the third paragraph B criterion, not the various psychological tests that may be administered for this purpose.

Comment: Two commenters took issue with the parenthetical phrase, ''which may include a loss of adaptive functioning,'' in the second sentence of proposed 12.00C4 and in the paragraph B4 and C1 criteria of the proposed listings. Both commenters contended that it was inappropriate to indicate that deterioration resulting from an episode of decompensation ''may include'' a loss of adaptive functioning. One of the commenters recommended deleting the phrase because it is unnecessary. The other commenter suggested we modify the sentence to read ''which may be considered to be a loss of adaptive functioning.''

Response: We adopted the comments. We revised the first paragraph of final 12.00C4 so that it now refers only to ''episodes of decompensation.'' We deleted the phrase ''causing deterioration'' and the parenthetical statement, ''which may include loss of adaptive functioning,'' and instead defined ''episodes of decompensation'' as ''exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning.'' We believe these changes better characterize the episodic nature of the functional limitations that the paragraph B4 and C1 criteria are designed to capture. We did not retain the word ''deterioration'' since it is often associated with long-term progressive changes in functioning; however, we added a new sentence that provides examples of how episodes of decompensation may be demonstrated.

In addition, we deleted the last sentence of proposed 12.00C4, which was the same as the last sentence in the prior rules. The sentence described some stressors common to work environments, such as decisions, attendance, and interactions with supervisors. Because we removed the focus of the section from stress in work environments, there is no reason to continue to describe work-related stresses in this paragraph. Moreover, sometimes the event that triggers the episode is not readily discernible, and we are more concerned with the effect of the stressor (i.e., decompensation), not its cause at this stage of the sequential evaluation process. Of course, when we determine whether an impairment is ''severe'' or assess an individual's RFC, we may want to know specifically the kinds of stressors and the degree of stress that result in exacerbations to determine what an individual is able to tolerate in work environments. Nevertheless, the severity level of the listings is such that the frequency and severity of the episodes alone are sufficient at this step.

As a result of these changes, we also deleted the words ''which cause the individual to deteriorate'' and ''causing deterioration'' from the references to episodes of decompensation in final §§ 404.1520a(c)(3) and (c)(4) and 416.920a(c)(3) and (c)(4), the second sentence in the introductory paragraph of final 12.00C, and the fourth sentence of final 12.00D1a. We made similar changes in the paragraph B4 and C1 criteria within each listing.

Comment: One commenter objected to the removal of the reference to withdrawal from the stressful situation found in the first sentence of prior 12.00C4. The commenter was concerned that, under stress, many individuals will withdraw from the stressful situation rather than stay and exhibit a deterioration in their functioning.

Response: We accommodated the comment in the aforementioned revision to the first paragraph of final 12.00C4. We never intended to eliminate withdrawal as a possible consequence of an episode of decompensation. Rather, as we stated in the preamble to the proposed rules (56 FR at 33132), we eliminated the specific reference to it for the opposite reason. Withdrawal is just one possible manifestation of decompensation; we did not want our revised rules to imply that it is the only manifestation we would consider.

Although we did not restore the word ''withdraw'' in the final rules, we built the concept into the revised definition of ''episodes of decompensation.'' Thus, in the first sentence of the first paragraph of final 12.00C4, we explain that the increase in symptoms or signs is ''accompanied by loss of adaptive functioning,'' in effect including a deterioration in the functional level in a given environment from which the individual could withdraw. More explicitly, in the second sentence, we further state that ''[e]pisodes of decompensation may be demonstrated by an exacerbation in symptoms or signs that would ordinarily require increased treatment or a less stressful situation * * *.'' The reference to a requirement for ''a less stressful situation'' obviously includes withdrawal from the stressful situation.

12.00D Documentation

Comment: Two commenters expressed concern about the medical documentation requirements in the proposed rules. One commenter, who did not refer to any particular provisions, said the proposed rules relied excessively on medical personnel and psychiatric records for decision making. The commenter expressed concern that many individuals with mental impairments receive only cursory evaluation and treatment, or even no treatment, and that it is difficult for case managers in the State mental health services to obtain more comprehensive reports. Moreover, the commenter explained that the medical personnel examining such individuals may not be sufficiently familiar with the individuals to provide the information we require. The commenter also stated that the records of case managers are often scanty and may not provide the functional information required to document the paragraph B criteria.

In a similar comment, the second commenter was concerned that proposed 12.00D placed too much reliance on the need to obtain evidence from treating sources. The commenter said that many individuals with mental impairments have no history of being treated for their mental disorders. Thus, this commenter said our emphasis on ''medical'' evidence tends to reward those who can afford treatment while penalizing poorer individuals. The commenter also noted that many individuals do not seek treatment for mental disorders because of the social stigma associated with these disorders.

Response: We clarified the rules in response to the comments. We share the concerns raised by both commenters and realize that obtaining medical evidence relating to an individual's mental impairment can be difficult. Nevertheless, we cannot ignore the specific statutory requirements for obtaining medical evidence. Furthermore, we are also required to try to obtain medical information from treating sources.

Our rules do not, however, require individuals to establish their claims solely on the basis of treating source evidence. If an individual does not have a treating source, or a treating source is unable or unwilling to provide sufficient information for us to make a determination or decision, we can purchase one or more consultative examinations, if necessary. Other regulations explain how we assist individuals in meeting their responsibility to submit evidence to support their claims.

When we evaluate the impact of an individual's impairment(s) on his or her functioning, we do not confine our inquiry to the medical evidence alone. As we have explained above, various other regulations, including final §§ 404.1520a and 416.920a, make clear that once we have established the existence of a medically determinable impairment, we consider all evidence in the case record that is relevant to our assessment of the individual's ability to function. This includes information from both medical and nonmedical sources. Proposed 12.00D was consistent with this policy, requiring medical evidence to establish the existence of a medically determinable impairment.

Nevertheless, in response to these and other comments, we substantially reorganized and revised final 12.00D to clarify our policies, as we discuss in detail in the explanation of the final rules in this preamble. Final 12.00D1a still requires medical evidence from acceptable medical sources. In combination, however, final 12.00D1, 12.00D2, and 12.00D3 emphasize that we will use information from all sources (medical and nonmedical) to assess the longitudinal picture of an individual's impairment(s) and the limitations it imposes.

Comment: We received a number of comments about the first two sentences in the second paragraph of proposed 12.00D concerning the usefulness of functional information provided by claimants. One commenter said that our statement that the individual ''usually can best describe his or her own functional limitations'' was ''naive thinking'' and ''unsubstantiated,'' and another commenter stated it was ''incorrect'' because individuals with brain damage may not be able to describe their own impairments. Most of the commenters, however, supported the provision, but asked us to clarify or expand it.

Four commenters recommended that we also require third party documentation. One commenter stated that such evidence should be obtained in each case to corroborate the individual's allegations. The other three commenters viewed third party reports as a means to protect claimants who are ''unreliable'' reporters because they are out of touch with reality or because they have disorders characterized by denial or lack of insight, such as psychoactive substance dependence disorders. In addition, one commenter suggested that we describe the form and manner in which the claimant's reports will be acceptable and delete any statements, such as those in the twelfth paragraph of proposed 12.00D, that impugn the value of psychometric measures based on self-reports.

Response: We revised the final rules in response to the comments. We believe that obtaining statements from the individuals is important, and that, with the exceptions noted by the latter commenters, individuals with mental impairments can provide much useful information and often are the best sources of information about their impairments. In response to the comments, however, we modified the final rules to remove the statement that such individuals can ''usually'' best describe their functional limitations and provided some of the additional guidance requested by the commenters.

The first sentence of final 12.00D1b, ''Information from the individual,'' now states that ''[i]ndividuals with mental impairments can often provide accurate descriptions of their limitations.'' We also added a new third sentence requiring an attempt to obtain information from the individual when the individual is willing and able to provide such information.

This does not mean that we will base our assessments solely on self-reports. We will consider the medical and other evidence in addition to an individual's statements, and any discrepancies must be resolved. This type of assessment process is consistent with standard medical practice: Medical sources consider their patients' allegations together with the signs they observe and any laboratory findings and third-party reports they obtain. Thus, in a new last sentence of the paragraph, we provide that statements from the individual must be carefully examined in light of all the evidence in the case record to determine whether the individual's statements are consistent with the other evidence and whether additional information is needed. Such information can come from medical or third-party reports, or both. We did not make third-party contact a requirement in every case because each case is different, and we believe the need for additional evidence should be dictated by the facts of each individual case.

We also agree that not all individuals with mental impairments are willing or able to fully or accurately describe the functional limitations arising from their impairments. Therefore, we added a new fourth sentence to the paragraph stating this policy.

Beyond these changes, we do not believe it is necessary or even possible for these final rules to dictate the form and manner in which self-reports will be acceptable. Each case has its own unique set of circumstances, and functional information from individuals comes to us in a variety of ways. For example, we may obtain information through our disability claims forms, through responses given in medical or psychological examinations or on standardized psychological tests, through telephone contacts, through written correspondence, and through detailed testimony at disability hearings at reconsideration and administrative law judge hearings.

Finally, we revised final 12.00D7 to be consistent with final 12.00D1b and to address concerns about the value of personality measures that rely on self-reports. We explain the revisions in a later comment and response. We believe the functional information an individual supplies should be an essential part of the disability case development process. We never intended to impugn the value of psychological measures that rely on such information.

Comment: Two commenters recommended that we discuss the Global Assessment of Functioning (GAF) Scale in the introductory paragraphs of final 12.00D. They noted that we referred to the GAF scale in the preamble to the NPRM (56 FR at 33132) and seemed to encourage its use, but then failed to mention it in the proposed rules.

Response: We did not adopt the comment. We did not mention the GAF scale to endorse its use in the Social Security and SSI disability programs, but to indicate why the third sentence of the second paragraph of proposed 12.00D stated that an individual's medical source ''normally can provide valuable additional functional information.'' To assess current treatment needs and provide a prognosis, medical sources routinely observe and make judgments about an individual's functional abilities and limitations. The GAF scale, which is described in the DSM–III–R (and the DSM–IV), is the scale used in the multiaxial evaluation system endorsed by the American Psychiatric Association. It does not have a direct

correlation to the severity requirements in our mental disorders listings.

Comment: Three commenters agreed with our statement in the fourth paragraph of proposed 12.00D that information from past employers about work attempts, behavior on the job, and the circumstances surrounding termination of a work effort is pertinent to determining an individual's ability to function in a work setting. However, two of the commenters pointed out that many individuals with mental impairments are now able to engage in specialized work programs, such as supported employment and transitional employment programs, because these programs provide significant on-the-job supports. Thus, they noted that an individual's success in one of these programs should not automatically be equated with the ability to work independently. They recommended that we revise the fourth paragraph of proposed 12.00D to instruct adjudicators to examine the degree to which an individual in one of these types of programs requires specialized supports in order to hold a job.

Response: We adopted the comments and revised final 12.00D3. We also modified the second sentence in final 12.00H, ''Effects of treatment,'' to emphasize that it is the ability to sustain SGA that must be restored. This recognizes that not all work activity fulfills our requirements for the performance of SGA.

Comment: We received many comments, primarily from psychologists and organizations of psychologists, but also from several advocates and others, about the proposed rules in the fifth, twelfth, thirteenth, and fourteenth paragraphs of proposed 12.00D. Many commenters perceived the proposed revisions as an attempt to deemphasize, discourage, or even preclude the use of psychological testing, especially personality measures and projective types of techniques.

Many of the commenters focused on what they considered to be denigrating comments about psychological testing in the proposed rules and an apparent change in our policy. Many commenters said that psychological testing alone should not be the sole basis of the decision, but neither should it be disregarded, because it can provide important additional information for a disability evaluation. A number of commenters said that, while such testing may not be a substitute for some of the findings we require, it often provides objective documentation of the basis for the findings. The commenters further observed that the same criticisms we made of psychological testing could also be made of x rays, CAT scans, EEGs, and other tests that document the presence or absence of a condition but may not be sufficient as a basis for making a decision. In a similar vein, many commenters also discussed the drawbacks of evidence from self-reports, clinical examinations, and lay evidence, and again pointed out the need to consider all of the relevant evidence. They said that, just as no single test should be dispositive, no test should be unacceptable either.

Some commenters discussed the objectivity and value of psychological testing. Some said that the tests we had singled out satisfy our criteria for a ''good test'' and, therefore, ought to be ''acceptable.''

Some commenters pointed out that the first sentence of the proposed fifth paragraph (which excluded the purchase of ''consultative examinations employing psychometric testing'' unless the required documentation of a mental impairment could not be obtained from other sources) seemed to be inconsistent with other statements in the adult and childhood mental disorders listings. At least one commenter questioned the practical utility of the proposed rules, asking how we would evaluate a report if it was based on both ''acceptable'' and ''unacceptable'' tests.

Some commenters thought that the reason we proposed the rules was that we do not always get appropriate information from individuals who perform psychological examinations for us. Some thought our adjudicators do not always request psychological tests that are appropriate for evaluating individual claims. These commenters said that instead of narrowing the use of psychological testing, we should instead provide more guidance to psychologists and establish standards for our adjudicators to determine the kinds of psychological tests to request.

The commenters offered several other arguments for retaining the prior rules or making other revisions to the proposed rules, which we do not summarize here in view of our response.

Response: We adopted many of the comments. We never intended to denigrate the validity and reliability of psychological testing or to reduce it to a subordinate or ''last resort'' position in the disability evaluation process. We also did not intend to present an unbalanced approach to the relative merits of the contents of the evidentiary record. Psychological testing should not be ignored or dismissed as being of lesser value to the disability evaluation process than any other relevant and available evidence. The results of well-standardized psychological tests can provide valid and reliable data useful to the disability evaluation process.

In response to the comments, we deleted the first sentence of the fifth paragraph of proposed 12.00D. Our intent in proposing the sentence was simply to emphasize the need to obtain all available information from sources of record before deciding to purchase a consultative examination for any other necessary documentation. We did not intend to prohibit the use of psychometric testing. This is consistent with our general policy on purchasing consultative examinations required by the Act and set out in our regulations. (See, *e.g.,* §§ 404.1512(f), 404.1519a(a), 416.912(f) and 416.919a(a)). We never intended, here or anywhere else in the proposed rules, to relegate psychometric testing to a subordinate role or to use it only as a ''last resort.'' We agree, however, that the proposed sentence could have given that impression. Since we already have detailed rules for the purchase of consultative examinations, there was no need to retain or revise the sentence and we deleted it.

We replaced the proposed twelfth and fourteenth paragraphs (the proposed paragraphs that addressed personality measures and projective techniques) with final 12.00D7, ''Personality measures and projective testing techniques.'' Comments about the twelfth paragraph pointed out that tests such as the MMPI fulfill all the salient characteristics of a good test under our rules, even though they are based on self-report. Other comments noted unclear references, such as the phrase, ''objective units of functional behavior,'' and the phrase, ''limited applicability,'' which one commenter thought could be misinterpreted to mean ''useless.'' Comments about the fourteenth paragraph argued that projective techniques can also yield valid and reliable data relevant for purposes of diagnosis and assessment of functional capacity, particularly because conclusions about the impairment are not made solely from the results of the projective techniques. Rather, those results are integrated with a comprehensive history, mental status examination, and objective psychological testing.

One commenter offered us alternatives for both proposed paragraphs, some of which we adopted. Final 12.00D7 addresses both personality testing and projective techniques, and explains that they may provide useful data for evaluating several types of mental disorders. Consistent with the public comments, we also provide that the results should be corroborated by other evidence,

including the results of other psychological tests, information obtained in the course of the clinical evaluation, and information from all relevant sources. We agree with the commenters that personality measures and projective techniques may provide valid and reliable data for our purposes. We also agree that the most reliable conclusions are drawn about an individual's mental impairment(s) and how it impacts on functioning from the overall assessment of all the relevant evidence available, including any psychological testing.

We did not include the second sentence of the twelfth paragraph of proposed 12.00D in final 12.00D7. We agree that the negative implications about the value of self-reports were inconsistent with other statements in the listings about the value of such information. Further, we recognize that the history, mental status examination, and standardized assessment procedures all rely to some extent on information reported by the individual.

In final 12.00D9, ''Screening tests,'' we revised the proposed thirteenth paragraph. We agree with several commenters that the phrase ''primary evidence'' in the third sentence of the proposed paragraph was unclear. We did not intend to prohibit the use of screening tests in the proposed rules. Rather, we only intended to indicate that, generally, such tests cannot be used apart from further testing, except when the response pattern is so obviously atypical as to render further testing unnecessary. Therefore, in final 12.00D9, we deleted the statements that singled out particular tests and provided that screening tests may be useful in uncovering potentially serious impairments, but often must be supplemented by other data. Thus, screening tests are not generally considered appropriate primary evidence for disability determinations. The final paragraph is based on the first, fourth, and fifth sentences of the thirteenth paragraph.

We also believe the restructured and revised provisions about psychological testing in final 12.00D clarify our intent with regard to its applicability to our disability programs and the issues raised by the commenters. We describe the changes, structure, and content of these final rules in the explanation of changes section of this preamble.

Comment: Several commenters took issue with our reference to ''a psychologist, psychiatrist, or other physician specialist'' in the fifth and seventh paragraphs of proposed 12.00D. They contended that psychiatrists and other physicians are not qualified to either administer or interpret psychological testing. Another commenter asked us to define the term ''other physician specialist'' and to provide examples.

Response: We responded to these comments by clarifying the final rules to better reflect our intent. We deleted the reference to ''a psychologist, psychiatrist, or other physician specialist'' and used the terms ''qualified specialist'' and ''specialist'' in final 12.00D5a and 12.00D5b. In final 12.00D5a, we defined a ''qualified'' specialist as one who is currently licensed or certified in the State to administer, score, and interpret psychological tests and who has the training and experience to perform the test.

We recognize that administering and interpreting standardized psychological assessment procedures is quite prominent in the training of psychologists. We also recognize that training in administering and interpreting such instruments is available to other members of the medical profession as well. Physicians other than psychiatrists (''other physician specialists'') who might receive such training include, among others, neurologists and pediatricians. We intended in the NPRM to emphasize that we will accept as valid for our program purposes any psychological test results administered and interpreted by a qualified specialist.

Comment: One commenter urged us to use the term ''licensed psychologist'' throughout the rules to avoid any question as to who is a psychologist. Another commenter asked if our requirements would preclude the use of tests performed by psychometricians under the supervision of licensed psychologists.

Response: We did not adopt the first comment. We do not believe it necessary to refer to ''licensed'' psychologists in these rules since we discuss licensing or certification of psychologists in other regulations, which explain who qualifies as an acceptable medical source. (See §§ 404.1513 and 416.913).

Tests performed by properly trained and experienced psychometricians who work under the supervision of licensed psychologists are acceptable for our program purposes.

Comment: One commenter suggested inserting the phrase ''or a range of responses or behaviors'' in the last sentence of the fifth paragraph of proposed 12.00D to acknowledge that some tests elicit a particular response or behavior while others elicit a range of responses or behaviors.

Response: We agree that some standardized psychological tests are designed to elicit a particular response while others elicit a range of responses. However, instead of inserting the suggested phrase, we simplified the sentence in final 12.00D5b to state that psychological tests are best considered as ''standardized sets of tasks or questions designed to elicit a range of responses.'' The word ''response'' would include a ''behavior,'' and the phrase ''a range of responses'' can refer to a single response or denote a variety of responses.

We also believe it is important that the discussion of psychological testing acknowledge that such testing can provide other useful data and that any test reports should include both the objective data and any clinical observations. Therefore, final 12.00D5b concludes with a slightly edited version of the first two sentences from the ninth paragraph of proposed 12.00D.

Comment: One commenter thought that the explanation of the terms ''validity'' and ''reliability'' in the sixth paragraph of proposed 12.00D, which described the salient characteristics of a good test, was an excellent clarification of terms. Another commenter, while commending our efforts to identify those characteristics, thought that the American Psychological Association's ''Standards for Educational and Psychological Testing'' (1985) provides more elaborate and relevant definitions that apply equally to all assessment techniques. A third commenter, while finding no fault with the proposed paragraph, found it inconsistent with the statements regarding the use of psychological testing in other paragraphs of proposed 12.00D. A fourth commenter suggested an alternative for the fourth salient characteristic of a good test (''wide scope of measurement'') because the proposed rules required that a psychological test measure a broad range of facets or aspects of the domain being assessed when, in fact, psychological tests provide a sample of an individual's behavior. Another commenter recommended that we delete the seventh paragraph of proposed 12.00D since it implied that an adjudicator could reject any test results that do not satisfy all four of the salient characteristics.

Response: We did not make any major changes to the four salient characteristics in final 12.00D5c. We believe the characteristics are sufficiently detailed for our purposes and capture the essence of the American Psychological Association's definitions. As we explain in an earlier response to

a comment, we never intended to relegate psychological testing to a secondary role. We believe that the revisions to final 12.00D will make clear that these characteristics are not inconsistent with our approach to psychological testing. We also believe that the description of the fourth characteristic in the final rules captures the fourth commenter's concerns, when considered with the rest of our discussion.

We did, however, modify the description of the third characteristic, appropriate normative data, by replacing the phrase ''must be comparable'' with ''can be compared'' and deleting the word ''recent.'' Both are editorial changes. The former revision makes the description of the characteristic easier to read. With the latter revision, we want to avoid any implication that these rules set a precise time limit on the acceptability of a measure still in common use in the psychological community.

In addition, we deleted the seventh paragraph of proposed 12.00D because we agree that it could have been misleading. We did not intend that any psychological test results submitted as part of the evidentiary record be arbitrarily dismissed as invalid simply because they failed to satisfy one or more of the four criteria for a good test outlined in final 12.00D5c. We would generally require a test we purchase as part of a consultative examination to satisfy all these criteria, and we would expect any psychological test results submitted by individuals to satisfy all the criteria. We will not, however, ignore or reject test results that do not satisfy all the criteria. As we explain in final 12.00D1 and in various other places in our regulations, we consider all evidence obtained when we make a determination. Any inconsistency between test results and other evidence would be resolved prior to making a determination.

Comment: One commenter recommended that, since the eighth paragraph in proposed 12.00D related directly to intelligence testing, we should place it after the eleventh paragraph of proposed 12.00D.

Response: We reorganized the rules, as we describe in the explanation of changes section of this preamble.

Comment: One commenter recommended changing ''should'' to ''shall'' in the second and third sentences of the ninth paragraph of proposed 12.00D, the paragraph that explained that psychological testing can also provide other useful data aside from the test results. The second sentence (now in final 12.00D5b) explained that test results should include both the objective data and a narrative description of clinical findings. The third sentence (now in final 12.00D6a) explained that narrative reports should comment on whether the specialist considered the IQ scores to be valid and consistent with the individual's developmental history and degree of functional limitation.

Response: We did not adopt the comment because it would have resulted in the same problem that was in the seventh paragraph of the proposed rules; it could have suggested that we would reject or ignore reports that did not satisfy the description. We used the word ''should'' to describe what we expect in reports of psychological testing. It is, therefore, appropriate in these contexts. In final 12.00D5b, we substituted the phrase ''any clinical observations'' for the proposed phrase ''a narrative description of clinical findings,'' to clarify that the report should include the specialist's observations about the individual's ability to do the test.

Comment: One commenter noted that we incorrectly identified the standard deviation of the revised Stanford-Binet scales as 15 in the tenth paragraph of proposed 12.00D, when it is actually 16.

Response: We corrected the second sentence in final 12.00D6c by changing the example so that it refers to ''the Wechsler series.'' Additionally, we made corresponding technical revisions to the ninth paragraph of 112.00D.

Comment: One commenter suggested that intelligence test scores should be expressed ''in terms of standard deviations from the mean (as not all tests have a mean of 100 and standard deviation of 15) and acknowledgement of the standard error of the measurement.''

Response: We did not adopt the comment. The only rules in these listings that require intelligence test scores are in listing 12.05. The second sentence of final 12.00D6c explains that the IQ scores in listing 12.05 reflect values from tests that are based on a mean of 100 and that use a standard deviation of 15. The third sentence of final 12.00D6c provides for the case in which IQs are obtained from standardized tests that deviate from a mean of 100 and standard deviation of 15 by requiring conversion of the findings on such tests to percentile ranks. This allows us to determine the actual degree of limitation and to compare the findings with those in the listings.

Beyond that, we do not believe that it is necessary to revise the rules as suggested. The IQ of 59 in final listing 12.05B falls between two and three standard deviations below the mean (three standard deviations would be an IQ of 55) on such tests, and we do not want to lower it to conform to a scheme that relies strictly on standard deviations.

Comment: One commenter noted that we used the term ''mental status examination'' in the twelfth paragraph of proposed 12.00D and recommended that we define the term in the final rules and include a list of required elements.

Response: We adopted the comment. We added a new final 12.00D4, which provides a brief description of the mental status examination and its components. The final rules do not provide a formal definition of the term ''mental status examination'' because we believe it is widely used and commonly understood in the mental health community. The rules explain, however, that the mental status examination is performed during the course of a clinical interview and is often partly assessed while the history is being obtained. We then provide a recitation of the elements that generally appear in a report of a comprehensive mental status examination.

Nevertheless, we did not intend to unfairly weigh any particular aspect of clinical assessment, or to attempt to dictate the content of the clinical evaluation. Therefore, although we added a statement about the content of a mental status examination to the final rules, we did not make this a ''required'' list of elements. In the last sentence of the paragraph, we explain that ''[t]he individual case facts determine the specific areas of mental status that need to be emphasized during the examination.''

Comment: One commenter was concerned that the statement in the fifteenth paragraph of proposed 12.00D that ''[e]xceptions to formal standardized psychological testing may be considered'' where appropriate examiners are ''not readily available'' could be subject to different interpretations. The commenter encouraged us to revise the proposed rules so there would be no possibility that a lack of a ''readily available'' psychological consultant could be used as a reason to fail to obtain the documentation necessary to adequately evaluate a claim.

Response: We adopted the comment. We deleted the word ''readily'' in final 12.00D6e. We did not intend to provide a loophole for adjudicators to avoid obtaining pertinent information in assessing any claim. Our procedure is to send an individual to the nearest appropriate resource when the case facts

warrant this type of development. It was our intent in the proposed fifteenth paragraph to address situations in which formal standardized psychological testing may be warranted, but is simply not available, and other evidence must be relied upon to make a determination.

Comment: A number of commenters questioned the inclusion of the last two sentences in the eighteenth paragraph of proposed 12.00D regarding neuropsychological examinations.

Some commenters were concerned that the sentences would have the practical effect of prohibiting the purchase of such tests and would discriminate against individuals who lack the resources to obtain the tests. Other commenters contended that our rules should place greater emphasis on the importance and utility of neuropsychological testing in identifying and evaluating cases where brain dysfunction is an issue.

One commenter said that the discussion of neuropsychological testing in the seventeenth paragraph was biased toward the use of the Luria-Nebraska and Halstead-Reitan. This commenter urged us to reword the discussion to give the examining psychologist the discretion to choose the most appropriate test for a given evaluation.

Another commenter also said that batteries such as the Luria-Nebraska and the Halstead-Reitan may be less effective than developing a suitable battery of tests that are appropriate to the individual's needs. This commenter suggested that we amend our guidelines to require specific tests of frontal lobe function in cases involving TBI.

Response: As a result of these comments, we modified the seventeenth and eighteenth paragraphs of proposed 12.00D (now combined in final 12.00D8).

We deleted the last two sentences of the proposed eighteenth paragraph. Our original intent in including these sentences was not to inhibit the use of neuropsychological testing or to somehow disadvantage those who do not have the resources to obtain such tests. We simply intended to emphasize the highly specialized nature of such testing and the need to exhaust all other more direct avenues before purchasing such procedures. The rule we proposed about considering the purchase of neuropsychological examinations ''only after all other more direct avenues of obtaining the needed documentation have been exhausted'' was very similar to the guidance in the first sentence of §§ 404.1519a(a)(1) and 416.919a(a)(1). The proposed rule also was similar to the rule in §§ 404.1519f and 416.919f, which states that ''[w]e will purchase only the specific examinations and tests we need to make a determination'' in a case. Since we already have such statements in our regulations, we do not believe the preface to the adult mental disorders listings needs to focus on our policies for purchasing consultative examinations.

We did not, however, delete the specific references to the Luria-Nebraska or the Halstead-Reitan. We do not believe the rules we proposed, or the final rules, are biased towards the use of these batteries. We made it clear that they are only examples of neuropsychological tests a qualified specialist may administer. Further, as both the proposed and the final rules provide, the specialist performing the test may select another battery of tests if he or she determines it would be more relevant. To clarify this point, we revised the final rules by substituting the words ''suspected brain dysfunction'' for ''referral issues'' to emphasize that the case facts, not any general preference for one test over another, should dictate what batteries are administered.

We believe this clarification also addresses the last commenter's point. We do not believe that the psychometric examination of frontal lobe function should be required in every case involving TBI. The areas of the brain and function affected by TBI differ according to the nature of the injury and the individual injured. When making determinations under our disability programs, we assess the need to test this specific area on an individual basis.

Comment: One commenter questioned the relevance and placement of the twenty-first paragraph of proposed 12.00D, the last paragraph in 12.00D of the prior rules. The paragraph gave examples of kinds of evidence that should be obtained and considered in cases in which the nature of the individual's impairment precludes standardized intelligence testing.

Response: We deleted the paragraph. Our intent in proposing to retain this paragraph from the former rules was to emphasize that documentation must be provided even in cases in which the cognitive impairment is of such magnitude as to preclude any type of psychological testing. We realized from the comment, however, that the paragraph could have suggested that this was a special case. In fact, we require this kind of evidence in other cases involving other impairments, even when an individual can be tested. Moreover, we believe that the revisions and restructuring of final 12.00D already provide more detail about this issue than the prior paragraph. In addition, other regulatory provisions give considerable detail about various sources of evidence about functioning. Therefore, the proposed paragraph is no longer necessary.

Comment: One commenter recommended that the twenty-second, twenty-third, and twenty-fourth paragraphs of proposed 12.00D have a separate heading.

Response: We adopted the comment. We provided separate headings for each of the last three paragraphs of the proposed rules: ''Traumatic brain injury (TBI)'' (final 12.00D10), ''Anxiety disorders'' (final 12.00D11), and ''Eating disorders'' (final 12.00D12).

Comment: One commenter, who was concerned that the proposed rules meant we would no longer use psychological tests for disability evaluations, wondered whether we would continue to use the Wechsler Intelligence Scales, the Bayley, and similar tests for disability evaluations in childhood cases involving suspected mental retardation.

Response: As we have explained, we will continue to use appropriate psychological tests in our disability evaluations. In any event (except as explicitly noted in the NPRM), the revisions to 12.00D would not have affected the rules in 112.00D, which continue to require the kinds of tests about which the commenter was concerned.

Comment: One commenter thought that we did not effectively utilize the most up-to-date psychological expertise in the proposed rules on psychological testing. This commenter and two others urged us to work closely with the American Psychological Association in formulating the final rules on psychological testing.

Response: We appreciate the commenters' concerns. We try to utilize the most up-to-date knowledge and expertise in all our rules. The individual experts who provided input on the proposed rules included psychologists with years of training and experience in our disability programs, as well as extensive knowledge of psychological testing procedures. Representatives of the American Psychological Association and many other individuals and representatives of public interest and advocacy groups also provided extensive comments on the proposed rules. We carefully considered all these comments in promulgating these final rules.

Comment: We received a few comments about matters that went beyond the scope of the listings, such as the role psychological consultants in the

State agencies should play in determining which, if any, psychological tests should be purchased in developing a claim, the instructions that State agencies should provide to consulting examiners from whom we purchase tests, and costs of testing.

Response: Because the comments exceeded the scope of these rules, we do not address them here. We will consider any recommendations as we formulate our internal procedures and instructions.

12.00F Effects of Structured Settings

Comment: We received three comments about proposed 12.00F. Two commenters indicated that the revisions we proposed to 12.00F were helpful. The third commenter stated that the discussion in this section of the preface should relate the paragraph C1 criterion to the identical paragraph B4 criterion.

Response: The intent of the last comment was unclear; therefore, we did not change 12.00F. Nevertheless, we clarified the paragraph C criteria and their relationship to the fourth paragraph B criterion by adding a new paragraph C2 criterion. This revision highlights the differences between the two sections, as explained under the comments about the paragraphs B4 and C criteria, discussed below.

12.02 Organic Mental Disorders

Comment: One commenter suggested that the more appropriate and clinically meaningful place for the criteria for organic mental disorders is in the neurological listings. The commenter stated that, although it might be worthwhile to note that an individual exhibits symptoms and signs that are consistent with specific categories of mental impairments, when these medical findings are the result of a traumatic injury to the brain, they should be considered in the context of the individual's neurological disorder.

Response: We did not adopt the comment. As we have explained, the diagnostic categories of mental disorders in these listings are based on the major categories of mental disorders found in the DSM. We chose this reference because it is the most widely used and accepted resource in the psychiatric and psychological communities, and its terminology is well-known to other medical and health-care professionals outside these two communities. Further, the diagnostic classification system found in the DSM is compatible with that of the ninth revision of the ''International Classification of Diseases, Clinical Modification'' (the ICD–9–CM), which has been the official system in this country for recording all diagnoses and diseases since 1979. Both the DSM and the ICD–9–CM categorize organic mental disorders as mental rather than neurological.

The fact that we classify organic mental disorders under the mental disorders body system does not mean that we ignore the neurological aspects of disorders such as TBI. One of the main reasons we added final 11.00F to the preface to the neurological listings and placed a cross-reference to it in final 12.00D10 (the 22nd paragraph of proposed 12.00D) was to ensure that our adjudicators give full consideration to both the neurological and mental limitations resulting from TBI.

Comment: We received many comments about the proposed revisions to the paragraph B4 and C1 criteria, first stated in listing 12.02, but repeated throughout the proposed listings. One commenter commended our efforts to more precisely quantify our standards for evaluating episodes of decompensation and another commenter approved of our proposal to remove the requirement that the episodes of decompensation occur in ''work or work-like settings.'' However, these and other commenters were concerned that the proposed criteria would be too rigid.

Some commenters stated that the proposed revisions, which included specific time and duration requirements, would substantially increase the severity level of each listing. These commenters believed that the revisions would thereby preclude numerous favorable determinations or decisions that would have been made at the listing step of the sequential evaluation process under the prior rules. Two of the commenters said that we had not provided any rationale, from either research findings or experience, to justify the tightening of this standard. One commenter believed that anyone who satisfied the proposed paragraph B4 criterion would meet the statutory definition of disability, irrespective of the presence or absence of the other paragraph B criteria.

Other commenters stated that the specificity of the proposed criteria was unreasonable, did not relate to the reality of mental disorders, and did not take into account individual differences. In addition, some were concerned that the proposed changes were not sensitive to the problems individuals with low incomes and mental impairments face, seemed to remove the degree of flexibility necessary for the exercise of appropriate clinical judgment, and ignored the fact that employers generally will not tolerate an individual's inability to function for even short periods of time if the periods of inability occur frequently. Like the first group of commenters, these commenters believed we had compromised the utility of the criteria because only a limited number of individuals could satisfy them. One commenter asserted that the proposed criteria were so rigid that no non-institutionalized individual could meet them, and that no one could satisfy them without being found eligible under the other paragraph B criteria.

In addition, one commenter stated that the evaluation of decompensation had been reduced to such an overly quantitative scale that its qualitative aspects, such as the degree of limitation and its interference with the individual's ability to function, were not addressed. Another commenter expressed concern that the proposed criteria were so specific that they might be enforced too rigidly and possibly be viewed as the preeminent rule on evaluating decompensation when deciding equivalence or assessing a claim at a later step in the sequential evaluation process.

Three other commenters addressed the documentation requirements of the proposed criteria. One commenter believed the rigidity of the criteria was incompatible with the principles in the third paragraph of proposed 12.00D, which recognize that an individual's level of functioning may vary considerably over time. This commenter also thought the proposed criteria were unrealistic because mental health providers report that they are often unable to distinguish and date discrete episodes of decompensation, especially when an individual is being treated on an outpatient basis. The other two commenters suggested that the adequacy of the evidence required to document the decompensation criteria would be dependent upon the individual's financial resources. One commenter opined that the criteria would discriminate against low-income individuals unless additional funding was provided for professionals to observe and record periods of decompensation.

Some commenters recommended retaining the prior rules, saying that they more effectively conveyed the concept of decompensation and its impact on an individual's ability to retain a job. Others suggested that we eliminate the chronological and durational tests for episodes of decompensation because the concept of ''repeated episodes'' means that the individual's decompensation is regular and recurring, which is sufficient to

make an individual unemployable. Still others suggested that we make the criteria more of a relative guide, and either move the word ''repeated'' back into the first sentence of proposed 12.00C4 or expand the criteria to permit different combinations of frequency and duration. Similarly, a commenter suggested that we provide a more complete explanation of the paragraph B4 criterion to prohibit restrictive interpretations, relax the criterion, or possibly even add other periods of time that would satisfy the criterion. It was also suggested that we incorporate a ''qualitative'' description of the criterion into proposed §§ 404.1520a(b)(2) and 416.920a(b)(2) similar to the first sentence of the introductory paragraph of proposed 12.00C.

Response: We did not adopt the comments that asked us to drop the proposed rules, but we revised the rules in response to the comments. We did not intend to tighten the severity requirements of the listings when we incorporated specific time and duration requirements in the proposed paragraph B4 and C1 criteria. We simply wanted to clarify existing regulatory policies and policy interpretations.

Part of the proposed rules were already inherent in the prior regulations, and we have been following a procedure similar to the proposed rules since shortly after we published the prior rules. The prior rules included a definition of the term ''repeated'' in former §§ 404.1520a(b)(3) and 416.920a(b)(3) (''three or more'' episodes). In procedural guidelines we issued in November 1985, we clarified that the paragraph B4 criterion would generally be fulfilled if there was documentation of ''three significant episodes of * * * decompensation, each of which is at least two weeks or longer, during the most recent adjudicative year.'' These guidelines also indicated that, ''[i]n circumstances in which the individual has more frequent but less marked (in terms of duration and effect) episodes of decompensation * * * medical judgment must be used to determine if the duration and effect are equivalent to that described above.''

We provided these guidelines because we received questions about how to apply the paragraph B4 criterion, and because the questions led us to conclude that paragraph B4 was incomplete. Contrary to what some of the commenters believed, an individual with repeated, brief episodes of exacerbation of symptoms and signs will not necessarily be unable to work. For instance, an individual with an anxiety disorder and a job considered stressful even to individuals without mental disorders might stay home from work for a day or two at a time because of symptoms of anxiety on three or four occasions during the course of a year. Even though the individual has withdrawn from the stressful situation because of an increase in symptoms, he or she clearly would not have a listing-level degree of limitation in this area. Indeed, the individual would probably be able to continue to do the job and certainly would be able to do less stressful work, assuming he or she had no other limitations. After promulgating the prior rules, we also received questions about the frequency of episodes, such as whether three episodes separated by intervals of several years could satisfy the listing criterion. That clearly was not the intent of the criterion. These kinds of examples and questions illustrated to us the need for more specificity in the listing.

In this regard, we believe that the standard of an average of three episodes in a year, or one every 4 months, lasting for 2 weeks each is reasonable for listing-level severity. If this standard is met or exceeded, it will establish that the paragraph B4 or C1 criteria are satisfied. Even if not met, it still serves as a measure of listing-level severity against which other combinations of frequency and duration of episodes may be judged on an individual basis. This standard is intentionally set at a high level of severity to correspond to the ''marked'' degree of limitation required by the other three paragraph B criteria. It also permits us to confidently include at the listing level all individuals who manifest the criteria, regardless of the nature and severity of the stressors that cause their episodes of decompensation or the particular responses (*e.g.*, withdrawal from the situation or hospitalization).

Because the proposed rules and these final rules reflect procedures we have been following for more than 14 years, we have significant experience with the approach. We believe that this approach has not caused the problems predicted by the commenters, will not result in our denying more claims, and is not a ''tightening'' of the listings.

Furthermore, although some individuals may satisfy the paragraph B4 criterion and at least one other paragraph B criterion, not every individual will. For instance, one cannot assume that all individuals who withdraw from a stressful situation to avoid exacerbating their symptoms for a total of only 6 weeks in the course of a year have listing-level impairments; some may not be disabled at all.

Finally, the criterion is consistent with the guidance in the third paragraph of proposed 12.00D (final 12.00D2). Rather, the criterion describes a special situation in which an individual's functioning varies considerably over time. An individual whose functioning is markedly limited more or less continuously when viewed on a longitudinal basis (that is, despite temporary variations in the level of functioning) would be evaluated under the first three of the paragraph B criteria. We intended the fourth criterion to evaluate the impairments of individuals who may function relatively well for relatively long periods between episodes of decompensation.

Nevertheless, after we reviewed the comments on our proposed changes to the paragraph B4 and C1 criteria, we realized that we could have made the proposed rules more comprehensive. Therefore, we made several changes. We replaced the lengthy and repetitive proposed paragraph B4 and C1 criteria in each listing with the term, ''repeated episodes of decompensation, each of extended duration.'' We also added a definition of the term to the second paragraph of final 12.00C4. We define the term, using the proposed paragraph B4 and C1 criteria, as ''an average of three episodes within 1 year, or once every 4 months, each lasting for at least 2 weeks.'' However, we go on to elaborate that judgment must be exercised to determine if episodes of differing frequency and duration are comparable in duration and effect to the stated criteria and may be substituted for the listed finding in a determination of equivalence. This expanded discussion provides for the assessment of individuals who have shorter but more frequent episodes, or less frequent but longer episodes. We added this discussion because it would not be feasible to specify every possible combination of frequency and duration of episodes, the level of stressors needed to cause exacerbations of an individual's symptoms or signs, and the severity of the individual's response. Thus, cases not satisfying the specific definition in 12.00C4 must be evaluated on an individualized basis using the principle of equivalence.

In the final rules, we do not specify that the three episodes must have occurred during the year prior to adjudication. We now believe that to do so would impose an artificial requirement that would be based on the eventual date of adjudication, not the true course of the impairment. It could also cause unnecessarily complex decisions when individuals with adverse determinations appeal, because

there will be more than one date of adjudication in such cases. In addition, it would have made decisions on closed periods of disability more difficult to make.

Unlike our prior regulations, we also do not state that there should be three ''or more'' episodes of decompensation. Since three episodes are sufficient to establish that the listing criterion is satisfied, it naturally follows that more than three episodes would also satisfy the criterion. More importantly, we want to convey the idea that more frequent episodes of decompensation may establish or even exceed listing-level severity, even without satisfying the 2-week duration requirement.

The new second sentence of the first paragraph of final 12.00C4 (described in an earlier comment and response) is also intended to respond in part to those commenters who were concerned about the documentation requirements for the paragraph B4 and C1 criteria, and the commenter who stated that we had not adequately described the qualitative aspects of these criteria. The sentence explains that episodes of decompensation may be demonstrated by an exacerbation in symptoms or signs that would ordinarily require increased treatment or a less stressful situation, or both. Other provisions in the final rules, already described, stress the need to consider all of the evidence in the record.

Documenting the precise beginning and ending dates of each episode of decompensation is generally unnecessary. As a practical matter, sufficient information about these dates can be inferred from medical records that show significant alterations in medication or the need for other increased treatment, from treating sources statements, or from other documentation, including from family and other sources who know the individual, that shows the need for a more structured psychological support system. We believe that the changes in the final rules, together with our ongoing outreach activities, will assist individuals with mental impairments to obtain benefits if they are eligible for them, regardless of their economic status or the extent of their psychosocial support systems.

Comment: One commenter questioned whether there would be any change in the way the paragraph B4 criterion is documented under the revised rules because the proposed paragraph B4 and C1 criteria were identical. The commenter noted that our operating guidelines for the prior rules indicated that the paragraph C1 criterion could be documented either in the same manner as the paragraph B4 criterion (i.e., with evidence substantiating the occurrence of the required episodes of decompensation) or with evidence showing that the disorder had ''resulted in such marginal adjustment that any increase in mental demands or change in the environment would be predicted to cause'' episodes of decompensation.

Response: We responded to the comment by expanding the paragraph C rules. The paragraph C criteria differ conceptually from the paragraph B criteria. The paragraph C criteria describe chronic mental disorders, i.e., disorders that have lasted for at least 2 years, in which there may be periods of remission of the individual's symptoms due to the effects of medication or psychosocial support with little or no improvement in the individual's capacity to function independently on a sustained basis. Individuals with such chronic mental disorders may experience a progressive change in mental functioning with each episode of deterioration or decompensation. This difference is reflected in the introductory statement of the paragraph C criteria, which requires the presence of a chronic mental disorder of at least 2 years' duration that has caused more than a minimal limitation in the ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support.

The paragraph B4 criterion assesses the significance of actual episodes of decompensation. A mental disorder need not be chronic to satisfy this criterion. However, there must be repeated exacerbations in the symptoms or signs, during which there is a loss of adaptive functioning. This loss of adaptive functioning is reflected by functional limitations in the areas described by the paragraph B1, B2, or B3 criteria, which individually need not satisfy the listing-level severity requirements.

We did not change the documentation requirements for the paragraph B4 criterion under the final rules. Such documentation will continue to be derived from the longitudinal history of the disorder. As a result of this comment, however, we added another criterion to paragraph C of final listings 12.02, 12.03, and 12.04. This criterion, the final paragraph C2 criterion, specifically covers the situation described in our existing operating instructions: Individuals with chronic mental disorders who may not experience episodes of decompensation because their symptoms and signs are attenuated by medical treatment or psychosocial support, but whose adjustment is so marginal that any increased stress would be predicted to result in such episodes.

In making this addition, we retained the paragraph C1 criterion. The paragraph C1 criterion is now reserved for individuals with chronic mental disorders who continue to experience repeated episodes of decompensation, even though their symptoms and signs may currently be attenuated by treatment. We also redesignated the proposed paragraph C2 criterion as the final paragraph C3 criterion. This criterion covers individuals whose chronic mental disorders have resulted in an inability to function outside a highly supportive living arrangement for at least 1 year with an indication of continued need for such an arrangement.

Comment: Many commenters favored our proposal to add paragraph C criteria to listings 12.02 (Organic mental disorders) and 12.04 (Affective disorders). Other commenters urged us to add these criteria to all of the mental disorders listings that contain paragraph B criteria; one commenter singled out listing 12.09 (Substance addiction disorders). These commenters maintained that our logic for extending the criteria to listings 12.02 and 12.04, i.e., to ''facilitate the evaluation process for individuals with chronic disorders in these categories'' (56 FR at 33131), also applies to the other listings because any mental disorder has the potential for being long-term.

Response: We did not adopt the comments. We agree that the disorders covered by listings 12.07 (Somatoform disorders), 12.08 (Personality disorders), and 12.09 can become chronic, but they generally do not present the same clinical picture as chronic disorders covered by listings with paragraph C criteria. Therefore, the disorders under these listings would probably not meet the paragraph C criteria, and we believe that adding such criteria to final listings 12.07, 12.08, and 12.09 is unnecessary. We also believe that including paragraph C criteria in listing 12.10 is unnecessary. Manifestations of autistic and other pervasive developmental disorders are almost always lifelong, and chronicity is generally not an issue. In the rare event that a disorder covered by listing 12.07, 12.08, 12.09, or 12.10 does not satisfy the paragraph B criteria but presents functional limitations of the severity described by the paragraph C criteria of the other listings, we can make a determination of medical equivalence.

Comment: Two commenters presented differing views on the requirements of the criteria in proposed paragraph C of listings 12.02, 12.03, and

12.04. One of the commenters questioned the need for the paragraph C1 criterion and suggested that we make the paragraph C2 criterion a stand-alone criterion. This commenter said that any impairment(s) that satisfies the introductory statement of the paragraph C criteria (by virtue of a 2-year history of an interference ''with basic work activity'') and the paragraph C1 criterion (resulting in repeated episodes of decompensation) would also satisfy the paragraph B3 and B4 criteria. Therefore, the commenter considered the paragraph C1 criterion superfluous because the fifth sentence of the first paragraph of 12.00A requires us to assess the mental impairment(s) under the paragraph B criteria before we apply the paragraph C criteria. In addition, the commenter stated that the paragraph C2 criterion need not be linked to the introductory paragraph, as the criterion's requirement for a ''[c]urrent history of 1 or more years' inability to function outside a highly supportive living arrangement with an indication of continued need for such arrangement'' is, by itself, a sufficient predictor of inability to work.

The other commenter commended us for our proposal to change the time requirement in the paragraph C2 criterion from 2 years to 1 year. The commenter believed that 1 year's duration for a highly supportive living arrangement together with an indication for its continued need is sufficient to demonstrate an inability to work.

Response: We believe there is a continued need for the paragraph C1 criterion. As we have already noted, the paragraph C1 criterion consists of two parts: An introductory statement requiring a medically documented history of a chronic mental disorder ''of at least 2 years'' duration that has caused more than a minimal limitation of ability to do any basic work activity, with symptoms or signs currently attenuated by medication or psychosocial support''; and a paragraph requiring repeated episodes of decompensation. Thus, while an individual satisfying the paragraph C1 criterion will also satisfy the paragraph B4 criterion, the paragraph B3 criterion's requirement for ''marked difficulties in completing tasks in a timely manner'' may not be satisfied.

Also, we do not agree that the proposed paragraph C2 criterion (the final paragraph C3 criterion) should be a stand-alone criterion, separate from the introductory paragraph. We include the 2-year requirement in the introductory paragraph of the paragraph C criteria because the alternative functional criteria are used to facilitate the evaluation of claims of individuals who, at the time of adjudication, already have chronic mental disorders. In such individuals, the more obvious symptoms of their chronic mental disorders may be lessened or attenuated by medication or psychosocial support, but the individuals remain disabled because the symptoms and signs of their impairments will return when they encounter stressful circumstances or leave their supportive or supervised environments. The 2-year time requirement in the introductory paragraph is taken from the DSM–III–R's definition of a chronic mental disorder. We will evaluate individuals who do not have chronic mental disorders under the paragraph B criteria.

We appreciate the favorable comment concerning our proposed modification to the prior paragraph C2 criterion. We proposed this change to better reflect the original intent of this criterion, which describes chronic mental disorders that have resulted in the need for structured environments to minimize stress and reduce overt symptomatology. We believe that a chronic mental disorder that has lasted at least 2 years and that results in a current history of inability to function outside a highly supportive environment for at least 1 year, with an indication of the continued need for such an arrangement, satisfies our definition of disability.

12.05 Mental Retardation

Comment: One commenter viewed the second paragraph of proposed listing 12.05 as requiring evidence of intelligence testing prior to age 18. The commenter offered several arguments why this would be difficult for adults to establish and why it would be preferable to use more recent information.

Response: We adopted the comment. We did not intend the second paragraph of proposed listing 12.05 to require intelligence testing (or other contemporary evidence) prior to age 18, but we believe that the proposed listing could be misinterpreted, even though it was the same as in the prior rules. The proposed listing, as in the prior rules, stated that the significantly subaverage general intellectual functioning with deficits in adaptive behavior must have been initially ''manifested'' during the developmental period. We have always interpreted this word to include the common clinical practice of inferring a diagnosis of mental retardation when the longitudinal history and evidence of current functioning demonstrate that the impairment existed before the end of the developmental period. Nevertheless, we also can see that the rule was ambiguous. Therefore, we expanded the phrase setting out the age limit to read: ''i.e., the evidence demonstrates or supports onset of the impairment before age 22.''

Comment: One commenter objected to our proposed insertion of the word ''an'' before ''additional and significant work-related limitation of function'' in proposed listing 12.05C and urged us to remove the word. The inclusion of the word ''an,'' the commenter said, ''could be read to mean that there must be at least one additional factor which in itself imposes significant work-related limitation of function''; prior listing 12.05C could ''be read to include additional limitations caused by a number of factors, some of which might not be significant standing alone.''

Response: We did not adopt the comment. We inserted the word ''an'' in listing 12.05C to clarify this rule. We always have intended that there be a separate physical or mental impairment apart from the claimant's mental retardation that imposes an additional and significant work-related limitation of function.

In addition, the comment made us realize that the phrase ''significant work-related limitation of function'' might not be clear. We always have intended the phrase to mean that the other impairment is a ''severe'' impairment, as defined in §§ 404.1520(c) and 416.920(c). We have explained this policy previously in our training manuals, in Social Security Ruling 98–1p, and in Social Security Acquiescence Ruling (AR) 98–2(8). Therefore, in response to this comment, we revised the fourth paragraph of final 12.00A, which explains how we assess the functional limitations of an additional impairment under listing 12.05C. The revised paragraph states that we will assess the degree of functional limitation the additional impairment imposes to determine if it significantly limits an individual's physical or mental ability to do basic work activities; ''*i.e.,* is a 'severe' impairment(s), as defined in §§ 404.1520(c) and 416.920(c).''

Sections 404.1520(c) and 416.920(c) note that we must base our assessment of whether an impairment is severe on the limitations that the impairment imposes on the individual's physical and mental abilities to do basic work activities. When we do this, we do not consider factors such as the individual's age, education, or past work experience. Thus, although the other impairment in listing 12.05C may not prevent the individual from doing his or her past work, it may still cause an ''additional

and significant work-related limitation of function.'' Conversely, if the other impairment prevents the individual from doing his or her past work because of the unique features of that work, but does not significantly limit the individual's ability to do basic work activities, we will find that the impairment does not satisfy the ''additional and significant work-related limitation of function'' requirement in listing 12.05C.

We make this point because the term ''significant work-related limitation of function'' was an issue in *Branham* v. *Heckler*, 775 F.2d 1271 (4th Cir. 1985) and *Flowers* v. *U.S. Department of Health and Human Services*, 904 F.2d 211 (4th Cir. 1990). We issued an acquiescence ruling, AR 92–3(4) (57 FR 8463), partially replaced by AR 93–1(4) (58 FR 25996), to explain our policies and how we would apply the holdings of the United States Court of Appeals for the Fourth Circuit in these cases. Similarly, as a result of *Sird* v. *Chater*, 105 F.3d 401 (8th Cir. 1997), which also addressed this issue, we issued an acquiescence ruling, AR 98–2(8) (63 FR 9279), to explain our policies and how we would apply the holding of the United States Court of Appeals for the Eighth Circuit in this case. We believe that these final rules sufficiently clarify the regulations at issue in the Fourth Circuit holdings in *Branham* and *Flowers*, and the Eighth Circuit holding in *Sird*, discussed above. Therefore, we are rescinding AR 92–3(4), AR 93–1(4), and AR 98–2(8) under the authority of 20 CFR 404.985(e)(4) and 416.1485(e)(4) concurrently with the effective date of these regulations.

Comment: One commenter questioned the applicability of paragraphs D4 and E4 in proposed listing 12.05. The commenter expressed concern that these paragraphs, which are identical to the paragraph B4 criterion for episodes of decompensation in the other listings, are not applicable to individuals with the impairments described in listing 12.05. The commenter pointed out that there is no reference to decompensation in the DSM–III–R's discussion of these disorders and that the term ''decompensation'' does not really apply to these disorders.

Response: We did not adopt the comment. The criteria in paragraph D4 of final listing 12.05 and paragraph B4 of final listing 12.10 take into account behavioral manifestations that could occur in individuals who have mental retardation or autistic disorder or other pervasive developmental disorders under our definition of ''decompensation'' in final 12.00C4. Individuals with these disorders usually have their lives structured to minimize stressful circumstances. When there are disruptions in their environments, their level of adaptive functioning may temporarily worsen. Moreover, even if the criterion will rarely apply to such individuals, retaining it only provides another method by which such individuals can establish that their impairments ''meet'' the listing. Retaining it also maintains consistency among all of the listings that include ''paragraph B'' criteria.

Comment: One commenter thought that proposed listing 12.05E, for autistic disorder and other pervasive developmental disorders, was ambiguous. The commenter said that the difference between it and listing 12.05A was not readily apparent.

Response: We accommodated this comment by deleting proposed listing 12.05E from the final rules and establishing a new listing 12.10, ''Autistic disorder and other pervasive developmental disorders.'' Final listing 12.05 is now for mental retardation only. When we originally included autism in listing 12.05, August 28, 1985 (50 FR 35050), our rationale was that both mental retardation and autism ''are developmental disabilities and the vast majority of autistic people have subnormal scores on intelligence testing.'' We included wording in the 1985 publication of listing 12.05D ''to address autistic individuals who do not have reduced IQ's.'' This wording caused some confusion, which we attempted to redress through a technical revision to listing 12.05D when we published the revised childhood mental disorders listings on December 12, 1990 (55 FR 51230). We further attempted to clarify the distinction in the proposed listings 12.05D and E. However, the comment indicates this still did not resolve the issue.

As a result, we decided to establish separate listings for these disorders consistent with the structure of the childhood mental disorders listings. Final listings 12.05 and 12.10 parallel listings 112.05 and 112.10 and therefore also further our efforts to maintain consistency between the adult and childhood mental disorders listings. Although many individuals diagnosed with autistic disorder or other pervasive developmental disorders may have an associated diagnosis of mental retardation, establishing separate listings for these disorders in the adult mental disorders listings, as in the childhood mental disorders listings, will eliminate the ambiguity of proposed listing 12.05 and more easily allow for individualized assessments of such cases.

We also modified the two introductory paragraphs of listing 12.05, as well as the fourth paragraph of 12.00A, to reflect the fact that final listing 12.05 contains only the diagnostic category of mental retardation.

Other Comments

General Comments

Comment: We received many favorable comments on the proposed rules. Some of the commenters identified specific aspects of the proposals that they endorsed as improvements. Other commenters, without naming specific portions of the proposals, stated that the proposals would clarify and improve the adjudicative process.

Response: The endorsement of general or specific aspects of the proposals was very useful in the development of the final rules. These comments, coupled with the constructive recommendations received from other commenters, helped us determine the nature and scope of the changes that we needed to make to the proposed rules.

Extend the Comment Period

Comment: One commenter requested that we extend the time period for commenting on the NPRM for an additional 2 months. The commenter was concerned that people would be deterred from commenting on the proposals because we published them during the summer, when most vacations take place, and we provided only a 60-day comment period.

Response: We usually provide 60-day comment periods on our proposed rules. Experience has shown that this is generally a sufficient period of time to afford people the opportunity to comment on proposed rules, even rules published during the summer. Moreover, in light of the fact that we received over 100 separate letters, it was apparent that the public was aware of the NPRM. Thus, we did not extend the 60-day comment period.

Multiple Personality Disorder

Comment: One commenter asked us to include a separate listing category for multiple personality disorder because it is a dissociative, rather than a personality, disorder and there were no criteria for it in the proposed listings. The commenter noted that this disorder is more common than once thought. Based on personal experience, the commenter believed it is at least as common as severe tic disorders.

Response: We did not adopt the comment. As we have stated above, the

adult mental disorders listings are not intended to be all-inclusive, but are designed to provide examples of some of the most common major mental disorders. This does not mean that an individual with an unlisted mental impairment(s) cannot be evaluated using these listing criteria. Such an individual may be found disabled if his or her impairment(s) is found to be medically equivalent in severity to a listed impairment. Disability may also be found at subsequent steps of the sequential evaluation process.

Workload, Staffing, and Training

Comment: One commenter believed the proposed rules would increase workloads and require either increased staffing or result in decreased productivity. The commenter said that State agencies will need considerable lead time to develop and provide training to disability examiners and medical consultants. The commenter also said that we, in conjunction with the State agencies, will need to develop materials to inform the medical community, the public, and advocacy groups about these changes.

Response: We do not believe that the final rules will cause increased workloads or necessitate increased staffing. The final rules contain relatively few major changes and should be easier to use because they include more guidelines than the prior rules and are clearer and simpler. Therefore, they should not impact adversely on decisionmakers. We believe the improvements in the revised rules will quickly offset any temporary decline in productivity that might occur as adjudicators become familiar with them.

With any regulatory change, we consider whether there is a need for training and public information. We have already developed, with assistance from some State agencies, training and public information materials to accompany these final rules. We do not believe, however, that the relatively few major changes contained in these rules require the kind of training and outreach suggested by the commenter.

Research

Comment: One commenter suggested that we engage in new research endeavors to provide a wider empirical base from which we can draw for policy and programmatic decisions. The commenter recommended several possible studies.

Response: We will consider the suggestions made by the commenter as we develop future research proposals.

Electronic Versions

The electronic file of this document is available on the internet at *http://www.access.gpo.gov/su_docs/aces/aces140.html.* It is also available on the internet site for SSA (i.e., ''SSA Online'') at *http://www.ssa.gov/.*

Regulatory Procedures

Executive Order 12866

The Office of Management and Budget (OMB) has reviewed these final in accordance with Executive Order (E.O.) 12866.

Regulatory Flexibility Act

We certify that these regulations will not have a significant economic impact on a substantial number of small entities because they affect only individuals' eligibility for program benefits under the Act. Therefore, a regulatory flexibility analysis as provided in the Regulatory Flexibility Act, as amended, is not required.

Paperwork Reduction Act

These final regulations will impose no new reporting or recordkeeping requirements requiring clearance by the Office of Management and Budget (OMB). SSA has OMB clearance to collect information in claims evaluated under part A of the Listings, using form SSA–2506–BK, Psychiatric Review Technique (OMB No. 0960–0413). Organizations or individuals desiring to submit comments on this information collection requirement should direct them to the Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235, Attention: Reports Clearance Officer, 1–A–21 Operations Building, and to the Office of Information and Regulatory Affairs, OMB, New Executive Office Building, Room 3208, Washington, D.C. 20503, Attention: Desk Officer for SSA.

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

List of Subjects

20 CFR Part 404

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

20 CFR Part 416

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

Dated: April 5, 2000.

Kenneth S. Apfel,

Commissioner of Social Security.

For the reasons set forth in the preamble chapter III of title 20 of the Code of Federal Regulations is amended as set forth below.

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

Subpart P—Determining Disability and Blindness

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

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

2. Section 404.1520a is revised to read as follows:

§ 404.1520a Evaluation of mental impairments.

(a) *General.* The steps outlined in § 404.1520 apply to the evaluation of physical and mental impairments. In addition, when we evaluate the severity of mental impairments for adults (persons age 18 and over) and in persons under age 18 when Part A of the Listing of Impairments is used, we must follow a special technique at each level in the administrative review process. We describe this special technique in paragraphs (b) through (e) of this section. Using the technique helps us:

(1) Identify the need for additional evidence to determine impairment severity;

(2) Consider and evaluate functional consequences of the mental disorder(s) relevant to your ability to work; and

(3) Organize and present our findings in a clear, concise, and consistent manner.

(b) *Use of the technique.* (1) Under the special technique, we must first evaluate your pertinent symptoms, signs, and laboratory findings to determine whether you have a medically determinable mental impairment(s). See § 404.1508 for more information about what is needed to show a medically determinable impairment. If we determine that you have a medically determinable mental impairment(s), we must specify the symptoms, signs, and laboratory findings that substantiate the presence of the impairment(s) and document our

findings in accordance with paragraph (e) of this section.

(2) We must then rate the degree of functional limitation resulting from the impairment(s) in accordance with paragraph (c) of this section and record our findings as set out in paragraph (e) of this section.

(c) *Rating the degree of functional limitation.* (1) Assessment of functional limitations is a complex and highly individualized process that requires us to consider multiple issues and all relevant evidence to obtain a longitudinal picture of your overall degree of functional limitation. We will consider all relevant and available clinical signs and laboratory findings, the effects of your symptoms, and how your functioning may be affected by factors including, but not limited to, chronic mental disorders, structured settings, medication, and other treatment.

(2) We will rate the degree of your functional limitation based on the extent to which your impairment(s) interferes with your ability to function independently, appropriately, effectively, and on a sustained basis. Thus, we will consider such factors as the quality and level of your overall functional performance, any episodic limitations, the amount of supervision or assistance you require, and the settings in which you are able to function. See 12.00C through 12.00H of the Listing of Impairments in appendix 1 to this subpart for more information about the factors we consider when we rate the degree of your functional limitation.

(3) We have identified four broad functional areas in which we will rate the degree of your functional limitation: Activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation. See 12.00C of the Listing of Impairments.

(4) When we rate the degree of limitation in the first three functional areas (activities of daily living; social functioning; and concentration, persistence, or pace), we will use the following five-point scale: None, slight, moderate, marked, and extreme. When we rate the degree of limitation in the fourth functional area (episodes of decompensation), we will use the following four-point scale: None, one or two, three, four or more. The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity.

(d) *Use of the technique to evaluate mental impairments.* After we rate the degree of functional limitation resulting from your impairment(s), we will determine the severity of your mental impairment(s).

(1) If we rate the degree of your limitation in the first three functional areas as ''none'' or ''mild'' and ''none'' in the fourth area, we will generally conclude that your impairment(s) is not severe, unless the evidence otherwise indicates that there is more than a minimal limitation in your ability to do basic work activities (see § 404.1521).

(2) If your mental impairment(s) is severe, we will then determine if it meets or is equivalent in severity to a listed mental disorder. We do this by comparing the medical findings about your impairment(s) and the rating of the degree of functional limitation to the criteria of the appropriate listed mental disorder. We will record the presence or absence of the criteria and the rating of the degree of functional limitation on a standard document at the initial and reconsideration levels of the administrative review process, or in the decision at the administrative law judge hearing and Appeals Council levels (in cases in which the Appeals Council issues a decision). See paragraph (e) of this section.

(3) If we find that you have a severe mental impairment(s) that neither meets nor is equivalent in severity to any listing, we will then assess your residual functional capacity.

(e) *Documenting application of the technique.* At the initial and reconsideration levels of the administrative review process, we will complete a standard document to record how we applied the technique. At the administrative law judge hearing and Appeals Council levels (in cases in which the Appeals Council issues a decision), we will document application of the technique in the decision.

(1) At the initial and reconsideration levels, except in cases in which a disability hearing officer makes the reconsideration determination, our medical or psychological consultant has overall responsibility for assessing medical severity. The disability examiner, a member of the adjudicative team (see § 404.1615), may assist in preparing the standard document. However, our medical or psychological consultant must review and sign the document to attest that it is complete and that he or she is responsible for its content, including the findings of fact and any discussion of supporting evidence. When a disability hearing officer makes a reconsideration determination, the determination must document application of the technique, incorporating the disability hearing officer's pertinent findings and conclusions based on this technique.

(2) At the administrative law judge hearing and Appeals Council levels, the written decision issued by the administrative law judge or Appeals Council must incorporate the pertinent findings and conclusions based on the technique. The decision must show the significant history, including examination and laboratory findings, and the functional limitations that were considered in reaching a conclusion about the severity of the mental impairment(s). The decision must include a specific finding as to the degree of limitation in each of the functional areas described in paragraph (c) of this section.

(3) If the administrative law judge requires the services of a medical expert to assist in applying the technique but such services are unavailable, the administrative law judge may return the case to the State agency or the appropriate Federal component, using the rules in § 404.941, for completion of the standard document. If, after reviewing the case file and completing the standard document, the State agency or Federal component concludes that a determination favorable to you is warranted, it will process the case using the rules found in § 404.941(d) or (e). If, after reviewing the case file and completing the standard document, the State agency or Federal component concludes that a determination favorable to you is not warranted, it will send the completed standard document and the case to the administrative law judge for further proceedings and a decision.

3. Section 404.1528 is amended by revising the third sentence of paragraph (b) to read as follows:

§ 404.1528 Symptoms, signs, and laboratory findings.

* * * * *

(b) * * * Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, e.g., abnormalities of behavior, mood, thought, memory, orientation, development, or perception. * * *

* * * * *

4. Part A of appendix 1 to subpart P is amended as follows:

a. The introductory text of 5.00, Digestive System, is amended by removing the last sentence of paragraph B.

b. The introductory text of 11.00, Neurological, is amended by adding a new paragraph F immediately before listing 11.01.

c. The introductory text of 12.00, Mental Disorders, including paragraphs A through I, is revised.

d. Listing 12.02 is amended by revising the second introductory paragraph and paragraphs B3 and B4, and adding a new paragraph C.

e. Listing 12.03 is amended by revising paragraphs B3, B4, and C.

f. Listing 12.04 is amended by revising the second introductory paragraph and paragraphs B3 and B4, and adding a new paragraph C.

g. Listing 12.05 is amended by revising the first paragraph, paragraph C, paragraph D introductory text, and paragraphs D3 and D4.

h. Listing 12.06 is amended by revising paragraphs B3 and B4.

i. Listing 12.07 is amended by revising paragraph B introductory text, and paragraphs B3 and B4.

j. Listing 12.08 is amended by revising paragraph B introductory text, and paragraphs B3 and B4.

k. Listing 12.10 is added.

The revisions and additions read as follows:

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

* * * * *

Part A

* * * * *

11.00 Neurological

* * * * *

F. *Traumatic brain injury (TBI).* The guidelines for evaluating impairments caused by cerebral trauma are contained in 11.18. Listing 11.18 states that cerebral trauma is to be evaluated under 11.02, 11.03, 11.04, and 12.02, as applicable.

TBI may result in neurological and mental impairments with a wide variety of posttraumatic symptoms and signs. The rate and extent of recovery can be highly variable and the long-term outcome may be difficult to predict in the first few months post-injury. Generally, the neurological impairment(s) will stabilize more rapidly than any mental impairment(s). Sometimes a mental impairment may appear to improve immediately following TBI and then worsen, or, conversely, it may appear much worse initially but improve after a few months. Therefore, the mental findings immediately following TBI may not reflect the actual severity of your mental impairment(s). The actual severity of a mental impairment may not become apparent until 6 months post-injury.

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

* * * * *

12.00 Mental Disorders

A. *Introduction.* The evaluation of disability on the basis of mental disorders requires documentation of a medically determinable impairment(s), consideration of the degree of limitation such impairment(s) may impose on your ability to work, and consideration of whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. The listings for mental disorders are arranged in nine diagnostic categories: Organic mental disorders (12.02); schizophrenic, paranoid and other psychotic disorders (12.03); affective disorders (12.04); mental retardation (12.05); anxiety-related disorders (12.06); somatoform disorders (12.07); personality disorders (12.08); substance addiction disorders (12.09); and autistic disorder and other pervasive developmental disorders (12.10). Each listing, except 12.05 and 12.09, consists of a statement describing the disorder(s) addressed by the listing, paragraph A criteria (a set of medical findings), and paragraph B criteria (a set of impairment-related functional limitations). There are additional functional criteria (paragraph C criteria) in 12.02, 12.03, 12.04, and 12.06, discussed herein. We will assess the paragraph B criteria before we apply the paragraph C criteria. We will assess the paragraph C criteria only if we find that the paragraph B criteria are not satisfied. We will find that you have a listed impairment if the diagnostic description in the introductory paragraph and the criteria of both paragraphs A and B (or A and C, when appropriate) of the listed impairment are satisfied.

The criteria in paragraph A substantiate medically the presence of a particular mental disorder. Specific symptoms, signs, and laboratory findings in the paragraph A criteria of any of the listings in this section cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) indicated by the medical findings. However, we may also consider mental impairments under physical body system listings, using the concept of medical equivalence, when the mental disorder results in physical dysfunction. (See, for instance, 12.00D12 regarding the evaluation of anorexia nervosa and other eating disorders.)

The criteria in paragraphs B and C describe impairment-related functional limitations that are incompatible with the ability to do any gainful activity. The functional limitations in paragraphs B and C must be the result of the mental disorder described in the diagnostic description, that is manifested by the medical findings in paragraph A.

The structure of the listing for mental retardation (12.05) is different from that of the other mental disorders listings. Listing 12.05 contains an introductory paragraph with the diagnostic description for mental retardation. It also contains four sets of criteria (paragraphs A through D). If your impairment satisfies the diagnostic description in the introductory paragraph and any one of the four sets of criteria, we will find that your impairment meets the listing. Paragraphs A and B contain criteria that describe disorders we consider severe enough to prevent your doing any gainful activity without any additional assessment of functional limitations. For paragraph C, we will assess the degree of functional limitation the additional impairment(s) imposes to determine if it significantly limits your physical or mental ability to do basic work activities, *i.e.,* is a ''severe'' impairment(s), as defined in §§ 404.1520(c) and 416.920(c). If the additional impairment(s) does not cause limitations that are ''severe'' as defined in §§ 404.1520(c) and 416.920(c), we will not find that the additional impairment(s) imposes ''an additional and significant work-related limitation of function,'' even if you are unable to do your past work because of the unique features of that work. Paragraph D contains the same functional criteria that are required under paragraph B of the other mental disorders listings.

The structure of the listing for substance addiction disorders, 12.09, is also different from that for the other mental disorder listings. Listing 12.09 is structured as a reference listing; that is, it will only serve to indicate which of the other listed mental or physical impairments must be used to evaluate the behavioral or physical changes resulting from regular use of addictive substances.

The listings are so constructed that an individual with an impairment(s) that meets or is equivalent in severity to the criteria of a listing could not reasonably be expected to do any gainful activity. These listings are only examples of common mental disorders that are considered severe enough to prevent an individual from doing any gainful activity. When you have a medically determinable severe mental impairment that does not satisfy the diagnostic description or the requirements of the paragraph A criteria of the relevant listing, the assessment of the paragraph B and C criteria is critical to a determination of equivalence.

If your impairment(s) does not meet or is not equivalent in severity to the criteria of any listing, you may or may not have the residual functional capacity (RFC) to do substantial gainful activity (SGA). The determination of mental RFC is crucial to the evaluation of your capacity to do SGA when your impairment(s) does not meet or equal the criteria of the listings, but is nevertheless severe.

RFC is a multidimensional description of the work-related abilities you retain in spite of your medical impairments. An assessment of your RFC complements the functional evaluation necessary for paragraphs B and C of the listings by requiring consideration of an expanded list of work-related capacities that may be affected by mental disorders when your impairment(s) is severe but neither meets nor is equivalent in severity to a listed mental disorder.

B. *Need for medical evidence.* We must establish the existence of a medically determinable impairment(s) of the required duration by medical evidence consisting of

symptoms, signs, and laboratory findings (including psychological test findings). Symptoms are your own description of your physical or mental impairment(s). Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, *e.g.,* abnormalities of behavior, mood, thought, memory, orientation, development, or perception, as described by an appropriate medical source. Symptoms and signs generally cluster together to constitute recognizable mental disorders described in the listings. The symptoms and signs may be intermittent or continuous depending on the nature of the disorder.

C. *Assessment of severity.* We measure severity according to the functional limitations imposed by your medically determinable mental impairment(s). We assess functional limitations using the four criteria in paragraph B of the listings: Activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation. Where we use ''marked'' as a standard for measuring the degree of limitation, it means more than moderate but less than extreme. A marked limitation may arise when several activities or functions are impaired, or even when only one is impaired, as long as the degree of limitation is such as to interfere seriously with your ability to function independently, appropriately, effectively, and on a sustained basis. See §§ 404.1520a and 416.920a.

1. *Activities of daily living* include adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for your grooming and hygiene, using telephones and directories, and using a post office. In the context of your overall situation, we assess the quality of these activities by their independence, appropriateness, effectiveness, and sustainability. We will determine the extent to which you are capable of initiating and participating in activities independent of supervision or direction.

We do not define ''marked'' by a specific number of different activities of daily living in which functioning is impaired, but by the nature and overall degree of interference with function. For example, if you do a wide range of activities of daily living, we may still find that you have a marked limitation in your daily activities if you have serious difficulty performing them without direct supervision, or in a suitable manner, or on a consistent, useful, routine basis, or without undue interruptions or distractions.

2. *Social functioning* refers to your capacity to interact independently, appropriately, effectively, and on a sustained basis with other individuals. Social functioning includes the ability to get along with others, such as family members, friends, neighbors, grocery clerks, landlords, or bus drivers. You may demonstrate impaired social functioning by, for example, a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, or social isolation. You may exhibit strength in social functioning by such things as your ability to initiate social contacts with others, communicate clearly with others, or interact and actively participate in group activities. We also need to consider cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority (*e.g.*, supervisors), or cooperative behaviors involving coworkers.

We do not define ''marked'' by a specific number of different behaviors in which social functioning is impaired, but by the nature and overall degree of interference with function. For example, if you are highly antagonistic, uncooperative, or hostile but are tolerated by local storekeepers, we may nevertheless find that you have a marked limitation in social functioning because that behavior is not acceptable in other social contexts.

3. *Concentration, persistence, or pace* refers to the ability to sustain focused attention and concentration sufficiently long to permit the timely and appropriate completion of tasks commonly found in work settings. Limitations in concentration, persistence, or pace are best observed in work settings, but may also be reflected by limitations in other settings. In addition, major limitations in this area can often be assessed through clinical examination or psychological testing. Wherever possible, however, a mental status examination or psychological test data should be supplemented by other available evidence.

On mental status examinations, concentration is assessed by tasks such as having you subtract serial sevens or serial threes from 100. In psychological tests of intelligence or memory, concentration is assessed through tasks requiring short-term memory or through tasks that must be completed within established time limits.

In work evaluations, concentration, persistence, or pace is assessed by testing your ability to sustain work using appropriate production standards, in either real or simulated work tasks (*e.g.*, filing index cards, locating telephone numbers, or disassembling and reassembling objects). Strengths and weaknesses in areas of concentration and attention can be discussed in terms of your ability to work at a consistent pace for acceptable periods of time and until a task is completed, and your ability to repeat sequences of action to achieve a goal or an objective.

We must exercise great care in reaching conclusions about your ability or inability to complete tasks under the stresses of employment during a normal workday or work week based on a time-limited mental status examination or psychological testing by a clinician, or based on your ability to complete tasks in other settings that are less demanding, highly structured, or more supportive. We must assess your ability to complete tasks by evaluating all the evidence, with an emphasis on how independently, appropriately, and effectively you are able to complete tasks on a sustained basis.

We do not define ''marked'' by a specific number of tasks that you are unable to complete, but by the nature and overall degree of interference with function. You may be able to sustain attention and persist at simple tasks but may still have difficulty with complicated tasks. Deficiencies that are apparent only in performing complex procedures or tasks would not satisfy the intent of this paragraph B criterion. However, if you can complete many simple tasks, we may nevertheless find that you have a marked limitation in concentration, persistence, or pace if you cannot complete these tasks without extra supervision or assistance, or in accordance with quality and accuracy standards, or at a consistent pace without an unreasonable number and length of rest periods, or without undue interruptions or distractions.

4. *Episodes of decompensation* are exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning, as manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace. Episodes of decompensation may be demonstrated by an exacerbation in symptoms or signs that would ordinarily require increased treatment or a less stressful situation (or a combination of the two). Episodes of decompensation may be inferred from medical records showing significant alteration in medication; or documentation of the need for a more structured psychological support system (*e.g.*, hospitalizations, placement in a halfway house, or a highly structured and directing household); or other relevant information in the record about the existence, severity, and duration of the episode.

The term *repeated episodes of decompensation, each of extended duration* in these listings means three episodes within 1 year, or an average of once every 4 months, each lasting for at least 2 weeks. If you have experienced more frequent episodes of shorter duration or less frequent episodes of longer duration, we must use judgment to determine if the duration and functional effects of the episodes are of equal severity and may be used to substitute for the listed finding in a determination of equivalence.

D. *Documentation.* The evaluation of disability on the basis of a mental disorder requires sufficient evidence to (1) establish the presence of a medically determinable mental impairment(s), (2) assess the degree of functional limitation the impairment(s) imposes, and (3) project the probable duration of the impairment(s). See §§ 404.1512 and 416.912 for a discussion of what we mean by ''evidence'' and how we will assist you in developing your claim. Medical evidence must be sufficiently complete and detailed as to symptoms, signs, and laboratory findings to permit an independent determination. In addition, we will consider information you provide from other sources when we determine how the established impairment(s) affects your ability to function. We will consider all relevant evidence in your case record.

1. *Sources of evidence.*

a. *Medical evidence.* There must be evidence from an acceptable medical source showing that you have a medically determinable mental impairment. See

§§ 404.1508, 404.1513, 416.908, and 416.913. We will make every reasonable effort to obtain all relevant and available medical evidence about your mental impairment(s), including its history, and any records of mental status examinations, psychological testing, and hospitalizations and treatment. Whenever possible, and appropriate, medical source evidence should reflect the medical source's considerations of information from you and other concerned persons who are aware of your activities of daily living; social functioning; concentration, persistence, or pace; or episodes of decompensation. Also, in accordance with standard clinical practice, any medical source assessment of your mental functioning should take into account any sensory, motor, or communication abnormalities, as well as your cultural and ethnic background.

b. *Information from the individual.* Individuals with mental impairments can often provide accurate descriptions of their limitations. The presence of a mental impairment does not automatically rule you out as a reliable source of information about your own functional limitations. When you have a mental impairment and are willing and able to describe your limitations, we will try to obtain such information from you. However, you may not be willing or able to fully or accurately describe the limitations resulting from your impairment(s). Thus, we will carefully examine the statements you provide to determine if they are consistent with the information about, or general pattern of, the impairment as described by the medical and other evidence, and to determine whether additional information about your functioning is needed from you or other sources.

c. *Other information.* Other professional health care providers (*e.g.*, psychiatric nurse, psychiatric social worker) can normally provide valuable functional information, which should be obtained when available and needed. If necessary, information should also be obtained from nonmedical sources, such as family members and others who know you, to supplement the record of your functioning in order to establish the consistency of the medical evidence and longitudinality of impairment severity, as discussed in 12.00D2. Other sources of information about functioning include, but are not limited to, records from work evaluations and rehabilitation progress notes.

2. *Need for longitudinal evidence.* Your level of functioning may vary considerably over time. The level of your functioning at a specific time may seem relatively adequate or, conversely, rather poor. Proper evaluation of your impairment(s) must take into account any variations in the level of your functioning in arriving at a determination of severity over time. Thus, it is vital to obtain evidence from relevant sources over a sufficiently long period prior to the date of adjudication to establish your impairment severity.

3. *Work attempts.* You may have attempted to work or may actually have worked during the period of time pertinent to the determination of disability. This may have been an independent attempt at work or it may have been in conjunction with a community mental health or sheltered program, and it may have been of either short or long duration. Information concerning your behavior during any attempt to work and the circumstances surrounding termination of your work effort are particularly useful in determining your ability or inability to function in a work setting. In addition, we should also examine the degree to which you require special supports (such as those provided through supported employment or transitional employment programs) in order to work.

4. *Mental status examination.* The mental status examination is performed in the course of a clinical interview and is often partly assessed while the history is being obtained. A comprehensive mental status examination generally includes a narrative description of your appearance, behavior, and speech; thought process (*e.g.*, loosening of associations); thought content (*e.g.*, delusions); perceptual abnormalities (*e.g.*, hallucinations); mood and affect (*e.g.*, depression, mania); sensorium and cognition (*e.g.*, orientation, recall, memory, concentration, fund of information, and intelligence); and judgment and insight. The individual case facts determine the specific areas of mental status that need to be emphasized during the examination.

5. *Psychological testing.*

a. Reference to a ''standardized psychological test'' indicates the use of a psychological test measure that has appropriate validity, reliability, and norms, and is individually administered by a qualified specialist. By ''qualified,'' we mean the specialist must be currently licensed or certified in the State to administer, score, and interpret psychological tests and have the training and experience to perform the test.

b. Psychological tests are best considered as standardized sets of tasks or questions designed to elicit a range of responses. Psychological testing can also provide other useful data, such as the specialist's observations regarding your ability to sustain attention and concentration, relate appropriately to the specialist, and perform tasks independently (without prompts or reminders). Therefore, a report of test results should include both the objective data and any clinical observations.

c. The salient characteristics of a good test are: (1) Validity, *i.e.*, the test measures what it is supposed to measure; (2) reliability, *i.e.*, the consistency of results obtained over time with the same test and the same individual; (3) appropriate normative data, *i.e.*, individual test scores can be compared to test data from other individuals or groups of a similar nature, representative of that population; and (4) wide scope of measurement, *i.e.*, the test should measure a broad range of facets/aspects of the domain being assessed. In considering the validity of a test result, we should note and resolve any discrepancies between formal test results and the individual's customary behavior and daily activities.

6. *Intelligence tests.*

a. The results of standardized intelligence tests may provide data that help verify the presence of mental retardation or organic mental disorder, as well as the extent of any compromise in cognitive functioning. However, since the results of intelligence tests are only part of the overall assessment, the narrative report that accompanies the test results should comment on whether the IQ scores are considered valid and consistent with the developmental history and the degree of functional limitation.

b. Standardized intelligence test results are essential to the adjudication of all cases of mental retardation that are not covered under the provisions of 12.05A. Listing 12.05A may be the basis for adjudicating cases where the results of standardized intelligence tests are unavailable, *e.g.*, where your condition precludes formal standardized testing.

c. Due to such factors as differing means and standard deviations, identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. The IQ scores in 12.05 reflect values from tests of general intelligence that have a mean of 100 and a standard deviation of 15; *e.g.*, the Wechsler series. IQs obtained from standardized tests that deviate from a mean of 100 and a standard deviation of 15 require conversion to a percentile rank so that we can determine the actual degree of limitation reflected by the IQ scores. In cases where more than one IQ is customarily derived from the test administered, *e.g.*, where verbal, performance, and full scale IQs are provided in the Wechsler series, we use the lowest of these in conjunction with 12.05.

d. Generally, it is preferable to use IQ measures that are wide in scope and include items that test both verbal and performance abilities. However, in special circumstances, such as the assessment of individuals with sensory, motor, or communication abnormalities, or those whose culture and background are not principally English-speaking, measures such as the Test of Nonverbal Intelligence, Third Edition (TONI–3), Leiter International Performance Scale-Revised (Leiter-R), or Peabody Picture Vocabulary Test—Third Edition (PPVT–III) may be used.

e. We may consider exceptions to formal standardized psychological testing when an individual qualified by training and experience to perform such an evaluation is not available, or in cases where appropriate standardized measures for your social, linguistic, and cultural background are not available. In these cases, the best indicator of severity is often the level of adaptive functioning and how you perform activities of daily living and social functioning.

7. *Personality measures and projective testing techniques.* Results from standardized personality measures, such as the Minnesota Multiphasic Personality Inventory-Revised (MMPI–II), or from projective types of techniques, such as the Rorschach and the Thematic Apperception Test (TAT), may provide useful data for evaluating several types of mental disorders. Such test results may be useful for disability evaluation when corroborated by other evidence, including results from other psychological tests and information obtained in the course of the clinical evaluation, from treating and other medical sources, other professional health care providers, and nonmedical sources. Any inconsistency between test results and

clinical history and observation should be explained in the narrative description.

8. *Neuropsychological assessments.* Comprehensive neuropsychological examinations may be used to establish the existence and extent of compromise of brain function, particularly in cases involving organic mental disorders. Normally, these examinations include assessment of cerebral dominance, basic sensation and perception, motor speed and coordination, attention and concentration, visual-motor function, memory across verbal and visual modalities, receptive and expressive speech, higher-order linguistic operations, problem-solving, abstraction ability, and general intelligence. In addition, there should be a clinical interview geared toward evaluating pathological features known to occur frequently in neurological disease and trauma, *e.g.*, emotional lability, abnormality of mood, impaired impulse control, passivity and apathy, or inappropriate social behavior. The specialist performing the examination may administer one of the commercially available comprehensive neuropsychological batteries, such as the Luria-Nebraska or the Halstead-Reitan, or a battery of tests selected as relevant to the suspected brain dysfunction. The specialist performing the examination must be properly trained in this area of neuroscience.

9. *Screening tests.* In conjunction with clinical examinations, sources may report the results of screening tests; *i.e.*, tests used for gross determination of level of functioning. Screening instruments may be useful in uncovering potentially serious impairments, but often must be supplemented by other data. However, in some cases the results of screening tests may show such obvious abnormalities that further testing will clearly be unnecessary.

10. *Traumatic brain injury (TBI).* In cases involving TBI, follow the documentation and evaluation guidelines in 11.00F.

11. *Anxiety disorders.* In cases involving agoraphobia and other phobic disorders, panic disorders, and posttraumatic stress disorders, documentation of the anxiety reaction is essential. At least one detailed description of your typical reaction is required. The description should include the nature, frequency, and duration of any panic attacks or other reactions, the precipitating and exacerbating factors, and the functional effects. If the description is provided by a medical source, the reporting physician or psychologist should indicate the extent to which the description reflects his or her own observations and the source of any ancillary information. Statements of other persons who have observed you may be used for this description if professional observation is not available.

12. *Eating disorders.* In cases involving anorexia nervosa and other eating disorders, the primary manifestations may be mental or physical, depending upon the nature and extent of the disorder. When the primary functional limitation is physical, *e.g.*, when severe weight loss and associated clinical findings are the chief cause of inability to work, we may evaluate the impairment under the appropriate physical body system listing. Of course, we must also consider any mental aspects of the impairment, unless we can make a fully favorable determination or decision based on the physical impairment(s) alone.

E. *Chronic mental impairments.* Particular problems are often involved in evaluating mental impairments in individuals who have long histories of repeated hospitalizations or prolonged outpatient care with supportive therapy and medication. For instance, if you have chronic organic, psychotic, and affective disorders, you may commonly have your life structured in such a way as to minimize your stress and reduce your symptoms and signs. In such a case, you may be much more impaired for work than your symptoms and signs would indicate. The results of a single examination may not adequately describe your sustained ability to function. It is, therefore, vital that we review all pertinent information relative to your condition, especially at times of increased stress. We will attempt to obtain adequate descriptive information from all sources that have treated you in the time period relevant to the determination or decision.

F. *Effects of structured settings.* Particularly in cases involving chronic mental disorders, overt symptomatology may be controlled or attenuated by psychosocial factors such as placement in a hospital, halfway house, board and care facility, or other environment that provides similar structure. Highly structured and supportive settings may also be found in your home. Such settings may greatly reduce the mental demands placed on you. With lowered mental demands, overt symptoms and signs of the underlying mental disorder may be minimized. At the same time, however, your ability to function outside of such a structured or supportive setting may not have changed. If your symptomatology is controlled or attenuated by psychosocial factors, we must consider your ability to function outside of such highly structured settings. For these reasons, identical paragraph C criteria are included in 12.02, 12.03, and 12.04. The paragraph C criterion of 12.06 reflects the uniqueness of agoraphobia, an anxiety disorder manifested by an overwhelming fear of leaving the home.

G. *Effects of medication.* We must give attention to the effects of medication on your symptoms, signs, and ability to function. While drugs used to modify psychological functions and mental states may control certain primary manifestations of a mental disorder, *e.g.,* hallucinations, impaired attention, restlessness, or hyperactivity, such treatment may not affect all functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the use of such drugs, particular attention must be focused on the functional limitations that may persist. We will consider these functional limitations in assessing the severity of your impairment. See the paragraph C criteria in 12.02, 12.03, 12.04, and 12.06.

Drugs used in the treatment of some mental illnesses may cause drowsiness, blunted effect, or other side effects involving other body systems. We will consider such side effects when we evaluate the overall severity of your impairment. Where adverse effects of medications contribute to the impairment severity and the impairment(s) neither meets nor is equivalent in severity to any listing but is nonetheless severe, we will consider such adverse effects in the RFC assessment.

H. *Effects of treatment.* With adequate treatment some individuals with chronic mental disorders not only have their symptoms and signs ameliorated, but they also return to a level of function close to the level of function they had before they developed symptoms or signs of their mental disorders. Treatment may or may not assist in the achievement of a level of adaptation adequate to perform sustained SGA. See the paragraph C criteria in 12.02, 12.03, 12.04, and 12.06.

I. *Technique for reviewing evidence in mental disorders claims to determine the level of impairment severity.* We have developed a special technique to ensure that we obtain, consider, and properly evaluate all the evidence we need to evaluate impairment severity in claims involving mental impairment(s). We explain this technique in §§ 404.1520a and 416.920a.

12.01 Category of Impairments, Mental

*12.02 Organic Mental Disorders: * * **

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

* * * * *

B. * * *

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic organic mental disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or

2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

*12.03 Schizophrenic, Paranoid and Other Psychotic Disorders: * * **

* * * * *

B. * * *

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic schizophrenic, paranoid, or other psychotic disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work

activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or

2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

12.04 *Affective Disorders:* * * *

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

* * * * *

B. * * *

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or

2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

12.05 *Mental retardation:* Mental retardation refers to significantly subaverage general intellectual functioning with deficits in adaptive functioning initially manifested during the developmental period; i.e., the evidence demonstrates or supports onset of the impairment before age 22.

* * * * *

C. A valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing an additional and significant work-related limitation of function;

* * * * *

D. A valid verbal, performance, or full scale IQ of 60 through 70, resulting in at least two of the following:

* * * * *

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration.

12.06 *Anxiety-Related Disorders:* * * *

* * * * *

B. * * *

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration.

* * * * *

12.07 *Somatoform Disorders:* * * *

* * * * *

B. Resulting in at least two of the following:

* * * * *

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration.

12.08 *Personality Disorders:* * * *

* * * * *

B. Resulting in at least two of the following:

* * * * *

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration.

* * * * *

12.10 *Autistic disorder and other pervasive developmental disorders:* Characterized by qualitative deficits in the development of reciprocal social interaction, in the development of verbal and nonverbal communication skills, and in imaginative activity. Often, there is a markedly restricted repertoire of activities and interests, which frequently are stereotyped and repetitive.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of the following:

1. For autistic disorder, all of the following:

a. Qualitative deficits in reciprocal social interaction; and

b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity; and

c. Markedly restricted repertoire of activities and interests;

OR

2. For other pervasive developmental disorders, both of the following:

a. Qualitative deficits in reciprocal social interaction; and

b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration.

5. Part B of appendix 1 to subpart P is amended as follows:

a. The introductory text of 112.00, Mental Disorders, is amended as follows:

i. By revising the second sentence of the third undesignated paragraph of 112.00A, the seventh undesignated paragraph of 112.00A, the eighth undesignated paragraph of 112.00A, and the third sentence of 112.00B;

ii. By adding a new paragraph between the second and third undesignated paragraphs in 112.00C;

iii. By revising the third sentence of the first paragraph of 112.00C1b;

iv. By revising 112.00D; and

v. By revising the second and third sentences of the first undesignated paragraph of 112.00F.

b. Listing 112.02 is amended by revising paragraph B2d.

c. Listing 112.05 is amended by revising paragraphs D and F.

d. Listing 112.10 is amended by revising paragraphs A2 and A2a.

The revised text is set forth as follows:

Appendix 1 to Subpart P—Listing of Impairments

* * * * *

Part B

112.00 Mental Disorders

A. * * *

* * * * *

* * * This is followed (except in listings 112.05 and 112.12) by paragraph A criteria (a set of medical findings) and paragraph B criteria (a set of impairment-related functional limitations). * * *

* * * * *

We did not include separate C criteria for listings 112.02, 112.03, 112.04, and 112.06, as are found in the adult listings, because for the most part we do not believe that the residual disease processes described by these listings are commonly found in children. However, in unusual cases where these disorders are found in children and are comparable to the severity and duration found in adults, we may use the adult listings 12.02C, 12.03C, 12.04C, and 12.06C criteria to evaluate such cases.

The structure of the listings for Mental Retardation (112.05) and Developmental and Emotional Disorders of Newborn and Younger Infants (112.12) is different from that of the other mental disorders. Listing 112.05 (Mental Retardation) contains six sets of criteria. If an impairment satisfies the diagnostic description in the introductory paragraph and any one of the six sets of criteria, we will find that the child's impairment meets the listing. For listings 112.05D and 112.05F, we will assess the degree of functional limitation the additional impairment(s) imposes to determine if it causes more than minimal functional limitations, *i.e.,* is a ''severe'' impairment(s), as defined in § 416.924(c). If the additional impairment(s) does not cause limitations that are ''severe'' as defined in § 416.924(c), we will not find that the additional impairment(s) imposes an additional and significant limitation of function. Listing 112.12 (Developmental and Emotional Disorders of Newborn and Younger Infants) contains five criteria, any one of which, if satisfied, will result in a finding that the infant's impairment meets the listing.

* * * * *

B. * * * Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, e.g., abnormalities of behavior, mood, thought,

memory, orientation, development, or perception, as described by an appropriate medical source. * * *

C. * * *

* * * * *

Generally, when we assess the degree of developmental delay imposed by a mental impairment, we will use an infant's or toddler's chronological age; *i.e.,* the child's age based on birth date. If the infant or toddler was born prematurely, however, we will follow the rules in § 416.924a(b) to determine whether we should use the infant's or toddler's corrected chronological age; i.e., the chronological age adjusted by the period of gestational prematurity.

* * * * *

1. * * *

b. * * * Screening instruments may be useful in uncovering potentially serious impairments, but often must be supplemented by other data. However, in some cases, the results of screening tests may show such obvious abnormalities that further testing will clearly be unnecessary.

* * * * *

D. *Documentation:* 1. The presence of a mental disorder in a child must be documented on the basis of reports from acceptable sources of medical evidence. See §§ 404.1513 and 416.913. Descriptions of functional limitations may be available from these sources, either in the form of standardized test results or in other medical findings supplied by the sources, or both. (Medical findings consist of symptoms, signs, and laboratory findings.) Whenever possible, a medical source's findings should reflect the medical source's consideration of information from parents or other concerned individuals who are aware of the child's activities of daily living, social functioning, and ability to adapt to different settings and expectations, as well as the medical source's findings and observations on examination, consistent with standard clinical practice. As necessary, information from nonmedical sources, such as parents, should also be used to supplement the record of the child's functioning to establish the consistency of the medical evidence and longitudinality of impairment severity.

2. For some newborn and younger infants, it may be very difficult to document the presence or severity of a mental disorder. Therefore, with the exception of some genetic diseases and catastrophic congenital anomalies, it may be necessary to defer making a disability decision until the child attains age 3 months of age in order to obtain adequate observation of behavior or affect. See, also, 110.00 of this part. This period could be extended in cases of premature infants depending on the degree of prematurity and the adequacy of documentation of their developmental and emotional status.

3. For infants and toddlers, programs of early intervention involving occupational, physical, and speech therapists, nurses, social workers, and special educators, are a rich source of data. They can provide the developmental milestone evaluations and records on the fine and gross motor functioning of these children. This information is valuable and can complement the medical examination by a physician or psychologist. A report of an interdisciplinary team that contains the evaluation and signature of an acceptable medical source is considered acceptable medical evidence rather than supplemental data.

4. In children with mental disorders, particularly those requiring special placement, school records are a rich source of data, and the required reevaluations at specified time periods can provide the longitudinal data needed to trace impairment progression over time.

5. In some cases where the treating sources lack expertise in dealing with mental disorders of children, it may be necessary to obtain evidence from a psychiatrist, psychologist, or pediatrician with experience and skill in the diagnosis and treatment of mental disorders as they appear in children. In these cases, however, every reasonable effort must be made to obtain the records of the treating sources, since these records will help establish a longitudinal picture that cannot be established through a single purchased examination.

6. Reference to a ''standardized psychological test'' indicates the use of a psychological test measure that has appropriate validity, reliability, and norms, and is individually administered by a qualified specialist. By ''qualified,'' we mean the specialist must be currently licensed or certified in the State to administer, score, and interpret psychological tests and have the training and experience to perform the test.

7. Psychological tests are best considered as standardized sets of tasks or questions designed to elicit a range of responses. Psychological testing can also provide other useful data, such as the specialist's observations regarding the child's ability to sustain attention and concentration, relate appropriately to the specialist, and perform tasks independently (without prompts or reminders). Therefore, a report of test results should include both the objective data and any clinical observations.

8. The salient characteristics of a good test are: (1) Validity, *i.e.,* the test measures what it is supposed to measure; (2) reliability, *i.e.,* the consistency of results obtained over time with the same test and the same individual; (3) appropriate normative data, *i.e.,* individual test scores can be compared to test data from other individuals or groups of a similar nature, representative of that population; and (4) wide scope of measurement, *i.e.,* the test should measure a broad range of facets/aspects of the domain being assessed. In considering the validity of a test result, we should note and resolve any discrepancies between formal test results and the child's customary behavior and daily activities.

9. Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. The IQ scores in listing 112.05 reflect values from tests of general intelligence that have a mean of 100 and a standard deviation of 15, *e.g.,* the Wechsler series. IQs obtained from standardized tests that deviate significantly from a mean of 100 and standard deviation of 15 require conversion to a percentile rank so that the actual degree of limitation reflected by the IQ scores can be determined. In cases where more than one IQ is customarily derived from the test administered, *e.g.,* where verbal, performance, and full scale IQs are provided in the Wechsler series, the lowest of these is used in conjunction with listing 112.05.

10. IQ test results must also be sufficiently current for accurate assessment under 112.05. Generally, the results of IQ tests tend to stabilize by the age of 16. Therefore, IQ test results obtained at age 16 or older should be viewed as a valid indication of the child's current status, provided they are compatible with the child's current behavior. IQ test results obtained between ages 7 and 16 should be considered current for 4 years when the tested IQ is less than 40, and for 2 years when the IQ is 40 or above. IQ test results obtained before age 7 are current for 2 years if the tested IQ is less than 40 and 1 year if at 40 or above.

11. Standardized intelligence test results are essential to the adjudication of all cases of mental retardation that are not covered under the provisions of listings 112.05A, 112.05B, and 112.05F. Listings 112.05A, 112.05B, and 112.05F may be the bases for adjudicating cases where the results of standardized intelligence tests are unavailable, *e.g.,* where the child's young age or condition precludes formal standardized testing.

12. In conjunction with clinical examinations, sources may report the results of screening tests, *i.e.,* tests used for gross determination of level of functioning. Screening instruments may be useful in uncovering potentially serious impairments, but often must be supplemented by other data. However, in some cases the results of screening tests may show such obvious abnormalities that further testing will clearly be unnecessary.

13. Where reference is made to developmental milestones, this is defined as the attainment of particular mental or motor skills at an age-appropriate level, *i.e.,* the skills achieved by an infant or toddler sequentially and within a given time period in the motor and manipulative areas, in general understanding and social behavior, in self-feeding, dressing, and toilet training, and in language. This is sometimes expressed as a developmental quotient (DQ), the relation between developmental age and chronological age as determined by specific standardized measurements and observations. Such tests include, but are not limited to, the Cattell Infant Intelligence Scale, the Bayley Scales of Infant Development, and the Revised Stanford-Binet. Formal tests of the attainment of developmental milestones are generally used in the clinical setting for determination of the developmental status of infants and toddlers.

14. Formal psychological tests of cognitive functioning are generally in use for preschool children, for primary school children, and for adolescents except for those instances noted below.

15. Generally, it is preferable to use IQ measures that are wide in scope and include items that test both verbal and performance abilities. However, in special circumstances,

such as the assessment of children with sensory, motor, or communication abnormalities, or those whose culture and background are not principally English-speaking, measures such as the Test of Nonverbal Intelligence, Third Edition (TONI–3), Leiter International Performance Scale-Revised (Leiter-R), or Peabody Picture Vocabulary Test—Third Edition (PPVT–III) may be used.

16. We may consider exceptions for formal standardized psychological testing when an individual qualified by training and experience to perform such an evaluation is not available, or in cases where appropriate standardized measures for the child's social, linguistic, and cultural background are not available. In these cases, the best indicator of severity is often the level of adaptive functioning and how the child performs activities of daily living and social functioning.

17. Comprehensive neuropsychological examinations may be used to establish the existence and extent of compromise of brain function, particularly in cases involving organic mental disorders. Normally these examinations include assessment of cerebral dominance, basic sensation and perception, motor speed and coordination, attention and concentration, visual-motor function, memory across verbal and visual modalities, receptive and expressive speech, higher-order linguistic operations, problem-solving, abstraction ability, and general intelligence. In addition, there should be a clinical interview geared toward evaluating pathological features known to occur frequently in neurological disease and trauma, *e.g.,* emotional lability, abnormality of mood, impaired impulse control, passivity and apathy, or inappropriate social behavior. The specialist performing the examination may administer one of the commercially available comprehensive neuropsychological batteries, such as the Luria-Nebraska or Halstead-Reitan, or a battery of tests selected as relevant to the suspected brain dysfunction. The specialist performing the examination must be properly trained in this area of neuroscience.

* * * * *

F. * * *

* * * While drugs used to modify psychological functions and mental states may control certain primary manifestations of a mental disorder, *e.g.,* hallucinations, impaired attention, restlessness, or hyperactivity, such treatment may not affect all functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the use of such drugs, particular attention must be focused on the functional limitations that may persist. * * *

112.01 Category of Impairments, Mental

112.02 *Organic Mental Disorders:* * * *

* * * * *

B. * * *

2. * * *

d. Marked difficulties in maintaining concentration, persistence, or pace.

* * * * *

112.05 *Mental Retardation:* * * *

* * * * *

D. A valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing an additional and significant limitation of function;

OR

* * * * *

F. * * *

1. For older infants and toddlers (age 1 to attainment of age 3), resulting in attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in paragraph B1b of 112.02, and a physical or other mental impairment imposing an additional and significant limitation of function;

OR

2. For children (age 3 to attainment of age 18), resulting in the satisfaction of 112.02B2a, and a physical or other mental impairment imposing an additional and significant limitation of function.

* * * * *

112.10 *Autistic Disorder and Other Pervasive Developmental Disorders:* * * *

A. * * *

* * * * *

2. For other pervasive developmental disorders, both of the following:

a. Qualitative deficits in the development of reciprocal social interaction; and

* * * * *

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

Subpart I—Determining Disability and Blindness

6. The authority citation for subpart I of part 416 continues to read as follows:

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

7. Section 416.920a is revised to read as follows:

§ 416.920a Evaluation of mental impairments.

(a) *General.* The steps outlined in §§ 416.920 and 416.924 apply to the evaluation of physical and mental impairments. In addition, when we evaluate the severity of mental impairments for adults (persons age 18 and over) and in persons under age 18 when Part A of the Listing of Impairments is used, we must follow a special technique at each level in the administrative review process. We describe this special technique in paragraphs (b) through (e) of this section. Using this technique helps us:

(1) Identify the need for additional evidence to determine impairment severity;

(2) Consider and evaluate functional consequences of the mental disorder(s) relevant to your ability to work; and

(3) Organize and present our findings in a clear, concise, and consistent manner.

(b) *Use of the technique.* (1) Under the special technique, we must first evaluate your pertinent symptoms, signs, and laboratory findings to determine whether you have a medically determinable mental impairment(s). See § 416.908 for more information about what is needed to show a medically determinable impairment. If we determine that you have a medically determinable mental impairment(s), we must specify the symptoms, signs, and laboratory findings that substantiate the presence of the impairment(s) and document our findings in accordance with paragraph (e) of this section.

(2) We must then rate the degree of functional limitation resulting from the impairment(s) in accordance with paragraph (c) of this section and record our findings as set out in paragraph (e) of this section.

(c) *Rating the degree of functional limitation.* (1) Assessment of functional limitations is a complex and highly individualized process that requires us to consider multiple issues and all relevant evidence to obtain a longitudinal picture of your overall degree of functional limitation. We will consider all relevant and available clinical signs and laboratory findings, the effects of your symptoms, and how your functioning may be affected by factors including, but not limited to, chronic mental disorders, structured settings, medication, and other treatment.

(2) We will rate the degree of your functional limitation based on the extent to which your impairment(s) interferes with your ability to function independently, appropriately, effectively, and on a sustained basis. Thus, we will consider such factors as the quality and level of your overall functional performance, any episodic limitations, the amount of supervision or assistance you require, and the settings in which you are able to function. See 12.00C through 12.00H of the Listing of Impairments in appendix 1 to subpart P of part 404 of this chapter for more information about the factors we consider when we rate the degree of your functional limitation.

(3) We have identified four broad functional areas in which we will rate the degree of your functional limitation: Activities of daily living; social functioning; concentration, persistence, or pace; and episodes of

decompensation. See 12.00C of the Listing of Impairments.

(4) When we rate the degree of limitation in the first three functional areas (activities of daily living; social functioning; and concentration, persistence, or pace), we will use the following five-point scale: None, slight, moderate, marked, and extreme. When we rate the degree of limitation in the fourth functional area (episodes of decompensation), we will use the following four-point scale: None, one or two, three, four or more. The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity.

(d) *Use of the technique to evaluate mental impairments.* After we rate the degree of functional limitation resulting from your impairment(s), we will determine the severity of your mental impairment(s).

(1) If we rate the degree of your limitation in the first three functional areas as ''none'' or ''mild'' and ''none'' in the fourth area, we will generally conclude that your impairment(s) is not severe, unless the evidence otherwise indicates that there is more than a minimal limitation in your ability to do basic work activities (see § 416.921).

(2) If your mental impairment(s) is severe, we must then determine if it meets or is equivalent in severity to a listed mental disorder. We do this by comparing the medical findings about your impairment(s) and the rating of the degree of functional limitation to the criteria of the appropriate listed mental disorder. We will record the presence or absence of the criteria and the rating of the degree of functional limitation on a standard document at the initial and reconsideration levels of the administrative review process, or in the decision at the administrative law judge hearing and Appeals Council levels (in cases in which the Appeals Council issues a decision). See paragraph (e) of this section.

(3) If we find that you have a severe mental impairment(s) that neither meets nor is equivalent in severity to any listing, we will then assess your residual functional capacity.

(e) *Documenting application of the technique.* At the initial and reconsideration levels of the administrative review process, we will complete a standard document to record how we applied the technique. At the administrative law judge hearing and Appeals Council levels (in cases in which the Appeals Council issues a decision), we will document application of the technique in the decision.

(1) At the initial and reconsideration levels, except in cases in which a disability hearing officer makes the reconsideration determination, our medical or psychological consultant has overall responsibility for assessing medical severity. The disability examiner, a member of the adjudicative team (see § 416.1015), may assist in preparing the standard document. However, our medical or psychological consultant must review and sign the document to attest that it is complete and that he or she is responsible for its content, including the findings of fact and any discussion of supporting evidence. When a disability hearing officer makes a reconsideration determination, the determination must document application of the technique, incorporating the disability hearing officer's pertinent findings and conclusions based on this technique.

(2) At the administrative law judge hearing and Appeals Council levels, the written decision issued by the administrative law judge or Appeals Council must incorporate the pertinent findings and conclusions based on the technique. The decision must show the significant history, including examination and laboratory findings, and the functional limitations that were considered in reaching a conclusion about the severity of the mental impairment(s). The decision must include a specific finding as to the degree of limitation in each of the functional areas described in paragraph (c) of this section.

(3) If the administrative law judge requires the services of a medical expert to assist in applying the technique but such services are unavailable, the administrative law judge may return the case to the State agency or the appropriate Federal component, using the rules in § 416.1441, for completion of the standard document. If, after reviewing the case file and completing the standard document, the State agency or Federal component concludes that a determination favorable to you is warranted, it will process the case using the rules found in § 416.1441(d) or (e). If, after reviewing the case file and completing the standard document, the State agency or Federal component concludes that a determination favorable to you is not warranted, it will send the completed standard document and the case to the administrative law judge for further proceedings and a decision.

8. Section 416.928 is amended by revising the third sentence of paragraph (b) to read as follows:

§ 416.928 Symptoms, signs, and laboratory findings.

* * * * *

(b) * * * Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, *e.g.*, abnormalities of behavior, mood, thought, memory, orientation, development, or perception. * * *

* * * * *

[FR Doc. 00–19648 Filed 8–18–00; 8:45 am]

BILLING CODE 4191–02–U