ACF Administration for Children and Families	U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Administration on Developmental Disabilities	
	1. Log No. ADD-IM-91-2	2. Issuance Date: 6/28/91
	3. Originating Office: Administration on Developmental Disabilities	
	4. Key Word: SSI	5.
	6.	7.

INFORMATION MEMORANDUM

To: Directors, State Administering Agencies
Executive Directors, State Planning Councils
Chairpersons, State Planning Councils
Directors, State Protection and Advocacy Systems
Directors, University Affiliated Programs and Satellite Centers

SUBJECT: Revised Regulations - Listing of Impairments - Evaluation of Disability for Children in the Supplemental Security Income (SSI) Program of the Social Security Administration (SSA)

CONTENT: SSA administers the SSI program which pays monthly checks to disabled and blind individuals (including children) who have limited income and resources. To help determine the medical criteria under the program, SSA maintains a "Listing of Impairment," which is the medical evaluation criteria that describe impairments in terms of specific symptoms, signs and laboratory findings. This listing is an essential part of the disability evaluation process.

As these regulations directly affect people with developmental disabilities and their families, the Administration on Developmental Disabilities is forwarding the regulations published on 12/12/90 and some summary information prepared by SSA. Topics include:

(1) Listing 110.06 for the evaluation of Down Syndrome;
(2) Listing 110.07 for the evaluation of other serious hereditary, congenital, or acquired disorders; and
(3) Section 112.00 childhood mental listings.

INQUIRIES TO: Elsbeth L. Wyatt
Program Specialist
Administration on Developmental Disabilities
Telephone: (202) 245-0841

Deborah L. McFadden
Commissioner
Administration on Developmental Disabilities

Attachments:
(1) SSA Regulation
(2) Summary of New Listings for Down Syndrome and Other Serious Hereditary, Congenital, or Acquired Disorders; and
(3) Summary of Changes in Revised Childhood Mental Listings

cc: Acting Regional Administrators, ACF

Federal Register

Wednesday
December 12, 1990

Part II

Department of Health and Human Services

Social Security Administration

20 CFR Parts 404 and 416

Federal Old-Age, Survivors, and Disability Insurance and Supplemental Security Income for the Aged, Blind, and Disabled; Final Rules

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Social Security Administration

20 CFR Part 404

[Regulations No. 4]

RIN 0960-AC35

Federal Old-Age, Survivors, and Disability Insurance; Determining Disability and Blindness; Addition of Down Syndrome and Other Serious Hereditary, Congenital or Acquired Disorders to the Listing of Impairments

AGENCY: Social Security Administration, HHS.

ACTION: Final rules.

SUMMARY: These amendments revise the criteria we use when we determine whether children's impairments meet or equal the severity of the impairments found in the multiple body system disorders listings. These final rules add new listings to the multiple body system category of impairments in part B of appendix 1, Listing of Impairments, to subpart P of part 404 of Title 20 of the Code of Federal Regulations. They provide separate listings for Down syndrome and for the evaluation of other hereditary, congenital, and acquired syndromes.

The Supreme Court's February 20, 1990, decision in *Sullivan* v. *Zebley, et al.*, _____ U.S. _____, 110 S.Ct. 885 (1990), requires us to provide an individual assessment of the functional impact of any child's impairment(s) when the impairment(s) does not meet or equal the severity of the impairments found in the Listing of Impairments. Since the Court's decision did not preclude the use of the listings as a basis for a decision that a child is disabled, the listings contained in these final rules will be used to determine that a child is disabled based on an impairment(s) that meets or equals the severity of a listed impairment. However, consistent with the Supreme Court's holding in *Zebley*, we will not deny any child's claim for Social Security or supplemental security income benefits based only on a finding that the child's impairment(s) does not meet or equal these, or any other, listings.

DATES: These rules are effective December 12, 1990.

FOR FURTHER INFORMATION CONTACT: William J. Ziegler, Legal Assistant, Office of Regulations, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235, (301) 965-1759.

SUPPLEMENTARY INFORMATION: Throughout this preamble and the regulatory text we refer to "Down syndrome" rather than "Down's syndrome." "Down" without the apostrophe "s" is the term currently being used by the National Down Syndrome Congress and the National Down Syndrome Society and is the term used in several major texts on childhood disability.

These final rules add new listings to the multiple body system category of impairments in Part B of the Listing of Impairments. They provide separate listings for Down syndrome and for the evaluation of other hereditary, congenital, and acquired syndromes.

These regulations were published in the Federal Register (52 FR 37161) as a Notice of Proposed Rulemaking (NPRM) on October 5, 1987. Interested parties were given 60 days to submit comments. We received comments from State government agencies, national organizations, and special interest organizations which deal with persons with disabilities.

Pursuant to public comments on the NPRM and our experience in administering the disability programs, we have made an important revision in the final rules. We have added a new final listing 110.06, solely for children who have non-mosaic Down syndrome, which provides that any child who has a medically established diagnosis of Down syndrome will be found to meet the listing. Final listing 110.07 is the listing we proposed as listing 110.06 in the NPRM. It is to be used to evaluate hereditary, congenital, and acquired conditions other than Down syndrome that have multiple body system effects similar to Down syndrome, and for cases of mosaic Down syndrome.

The primary purpose of establishing these new listings is to update the evaluation process under the Listing of Impairments. Part A of Appendix 1, Listing of Impairments, describes, for each of the major body systems, impairments that are considered severe enough to prevent a person from doing any gainful activity, absent evidence to the contrary. Part B of Appendix 1 contains additional medical criteria that apply only to the evaluation of impairments of persons under age 18.

Until the publication of this rule, we did not have a specific listing for Down syndrome. Instead, most children with Down syndrome were evaluated under the criteria of listing 112.05—Mental Retardation—which requires measurement of intellectual functioning or of the failure to attain expected developmental milestones. Although this policy identified disability in most children with Down syndrome, it was not always adequate for assessing the impairments of the youngest children, especially infants from birth to 6 months of age, in whom the multiple manifestations of impairment cannot be easily evaluated. As a consequence, we have been following a procedure whereby we have deferred the evaluation of the impairments of infants until they attained 6 months of age in those cases in which we were unable to find the applicant disabled or to evaluate properly the effects of the impairment.

However, after more than 2 years of applying the procedure, it has become apparent to us that virtually all infants who have Down syndrome of the Trisomy 21, regular and translocation types, (i.e., all except those who have mosaic Down syndrome) will be found disabled when the effects of their impairments can be properly documented and evaluated. In a recent study we conducted of 152 claims filed on behalf of infants and children with Down syndrome, we found that all children with non-mosaic Down syndrome could establish that they met or equaled our listings by the age of 6 months. In addition, 77 percent of 4-to-5-month-old infants could be found to meet or equal a listing. Consequently, we have changed our regulations to reflect these new data and our new policy.

We have also made this change in response to interest in the evaluation of childhood disability from some members of Congress, the public, advocacy groups, and others. During the past 2 years, legislation has been introduced in both Houses of Congress which, if enacted, would establish a rebuttable presumption of disability for children under age 4 with congenital or genetic impairments, including Down syndrome. Two of the commenters on the NPRM suggested that we have a separate listing for Down syndrome. We have also recently met with advocates for the rights of disabled children, who urged us to consider creating a category of disability for infants based on the diagnosis of Down syndrome. Finally, as we draft new rules to comply with the Supreme Court's decision in *Zebley*, we have been consulting with experts in childhood disability. All of the experts who addressed the subject supported the idea that infants with Down syndrome should be found disabled by virtue of the diagnosis and its well-established medical and functional implications.

Other conditions, including mosaic Down syndrome, that can affect several

body systems in ways similar to Down syndrome, will be evaluated under listing 110.07, which we originally proposed as listing 110.06. Conditions to be evaluated under this listing (for example, PKU and fetal alcohol syndrome) can certainly be disabling, but are not as invariably disabling as non-mosaic Down syndrome. The new listing 110.07 will facilitate and expedite adjudication and help to ensure that proper consideration is given to the variety of possible manifestations of these disorders.

Mosaic Down syndrome is a rare form of the condition which manifests a wide range of impairment severity. The condition can be profound and disabling, but it can also be so slight as to go undetected. Therefore, we do not believe that it would be appropriate to find that individuals meet the listing based solely on this diagnosis. However, we want to stress that children with mosaic Down syndrome can still be found disabled if they meet or equal final listing 110.07; furthermore, under the new policy we follow pursuant to the Supreme Court's decision in *Zebley*, we may also find such children disabled based upon an individualized assessment of their functioning, even if they do not have an impairment that meets or equals these new listings, or any other listings.

Listing 110.07 will also be used to evaluate those claims of children with mental retardation of known causes associated with impairments of other body systems. However, listing 112.05, relating to mental retardation, is being retained because it will continue to be needed to evaluate the large number of claims in which mental retardation is alleged but in which the medical cause cannot be medically identified.

We are also revising the introductory material in 110.00 to identify better what is meant by the term "catastrophic congenital abnormalities or diseases" and to describe a level of severity which is considered sufficient to find a person disabled by these abnormalities or diseases. We have expanded the introduction by including several major congenital abnormalities that do not fall into the "catastrophic" category described in listing 110.08. We believe these changes will help ensure greater uniformity and equity in the adjudicative process for children with conditions that usually affect more than one body system.

In response to other concerns expressed by the commenters, we have also revised the documentation requirements in proposed 110.00C (110.00B in the final regulations) to indicate that medical evidence that is persuasive that a positive diagnosis of non-mosaic Down syndrome has been confirmed by appropriate laboratory testing, at some time prior to evaluation, is acceptable in lieu of a copy of the actual laboratory findings. Paragraph A of final listing 110.07 (proposed listing 110.06) has also been revised to include additional neurological and developmental criteria to assure wider application to other impairments that are intended to be covered, and the documentation requirements in 110.00B (previously in proposed 110.00C) have been revised to prevent any possible conflicts between the documentation of Down syndrome and other impairments evaluated under this listing.

The comments we received and the changes we have made are addressed in more detail in the following discussion. We condensed, summarized, or paraphrased many of the written comments we received. We received several comments which did not pertain to the proposed changes in the listings; we have referred them to the appropriate Social Security office for reply.

Discussion of General Comments

Comment: Two commenters expressed the belief that the proposed listing did not adequately address the major adjudicative problem with Down syndrome; that is, of children less than a year old. These comments expressed the view that the listing should define appropriate developmental milestones in early life and provide guidelines for testing younger infants with Down syndrome. One of the commenters suggested that we consider such claimants as presumptively disabled and subsequently evaluate the claim.

Response: The comment has been adopted in part. We have provided in final listing 110.06 that when non-mosaic Down syndrome is established by clinical and laboratory findings the child will be considered disabled from birth. Although some older claimants will benefit from the new listing, we expect that the greatest benefit of this new listing will be in its application to young infants, especially from birth to 6 months. With regard to the comment on defining milestones and providing guidelines for testing, the discussion in 112.00B applies to evaluating milestones and age-appropriate activities in children with any impairment. We will also provide additional guidance in the revised childhood mental listings and in the new regulations we are now preparing in response to the Supreme Court's decision in *Zebley*.

Comment: Another comment noted that the proposed listing included other hereditary and congenital conditions as well as Down syndrome. The commenter suggested that a separate listing be established for Down syndrome. A similar comment expressed concern that the combining of Down syndrome with other impairments could result in conflicts regarding documentation.

Response: We agree with the comments. We have, therefore, added a separate listing 110.06 for non-mosaic Down syndrome, and redesignated the listing we proposed as 110.06 as final listing 110.07. Proposed listing 110.06 was developed primarily to address evaluation considerations specific to Down syndrome; however, there are many other conditions that manifest similar multisystem impairments for which final listing 110.07 can ensure a more accurate evaluation of disability. We have also revised this listing to clarify the documentation requirements to ensure that conflicts regarding documentation between Down syndrome and other impairments will not result.

Discussion of Specific Comments

110.00 Multiple Body Systems

Comment: One commenter stated that the criteria we proposed in 110.00B were not clear as to whether anencephaly and Tay-Sachs disease should be evaluated under proposed listing 110.06, which required functional limitations, or under listing 110.08, which provides for an allowance on the basis of diagnosis and prognosis alone.

Response: We agree with the comment and have clarified the criteria that were in proposed 110.00B. Catastrophic conditions such as anencephaly and Tay-Sachs disease where early death or profound development impairment is reasonably certain, should continue to be adjudicated according to listing 110.08. We have revised paragraphs A and B of 110.00 to make this clear. A new paragraph A incorporates in the final regulation the major features previously found in the paragraphs A and B of the proposed regulations.

Comments: One commenter suggested that the phrases "fetal alcohol syndrome" and "severe chronic neonatal infection" in proposed 110.00B be omitted because they did not describe any specific diagnostic entities. Another reason the commenter recommended that "fetal alcohol syndrome" should be omitted was that there was no specific diagnostic test as required by proposed 110.00C.

Response: The comment was not adopted. "Fetal alcohol syndrome" is a medical term used to describe the triad of specific dysmorphic facial features, growth deficiency, and central nervous system dysfunction including hypotonia, interference with motor coordination, and mental retardation. The term "severe chronic neonatal infection" refers primarily to those diagnostic conditions such as toxoplasmosis, rubella, cytomegalic inclusion disease, herpes encephalitis, and other serious infectious processes that can result in long-term impairment in infants and young children. Further, the intent of 110.00C was to require definitive tests in only those instances where appropriate, i.e., such a test is available and usually performed in accordance with accepted medical practice in order to confirm the presence of a medical condition. In response to the commenter, the explanatory material in the final 110.00B has been revised to make this clear.

Comment: Another commenter pointed out that "fetal alcohol syndrome" may be suspected by clinical findings but cannot be confirmed by laboratory methods, whereas other conditions such as Down syndrome can be clearly diagnosed through laboratory studies; thus making a clinical description redundant and superfluous. The commenter recommended that proposed 110.00C be revised to require definitive laboratory tests or a clinical description, whichever is appropriate.

Response: The comment was not adopted because a positive diagnosis of Down syndrome cannot be established through the results of laboratory testing alone. The use of laboratory tests is limited to confirmation of a diagnosis that has been suggested on the basis of clinical descriptive evidence. Therefore, the documentation must include a clinical description of the physical findings as well as definitive laboratory tests where appropriate.

Comment: A commenter expressed concern that the material in parenthesis in 110.00B was not as clear as the developmental milestone discussion in the third paragraph of 112.00B and suggested that the discussion in the third paragraph of 112.00B be repeated or referred to in 110.00B.

Response: We agree with the comment and have revised the final rule. A reference to the discussion of developmental criteria that appears in 112.00 has been added to final 110.00A. This will clarify that the parenthetical material was not meant to be discussion of developmental milestone criteria but to provide specific guidance as to what would constitute a significant interference with age-appropriate activities.

Comment: One commenter stated that the discussion of age-appropriate activities in 110.00B appeared in conflict with the description in proposed paragraph A of listing 110.06. In 110.00B, we define significant limitation of age-appropriate activities in an infant as developmental milestone age not exceeding two-thirds of chronological age at the time of evaluation. That criterion was not included in paragraph A of proposed listing 110.06, where age-appropriate activities stand alone, but did appear in paragraph B of proposed listing 110.06, where an additional impairment was required to meet the listing.

Response: We disagree. The definition that we proposed in 110.00B (110.00A2 in the final regulation), of what constitutes a significant interference with age-appropriate activities in an infant, is to be used in evaluating claims under both paragraphs A and B of final listing 110.07 (proposed listing 110.06). A severity level has been established under paragraph A of listing 110.07 in the final regulations which is internally consistent with that required under paragraph B of listing 110.07 in the final regulations. The additional impairment in paragraph A of listing 110.07, which corresponds to the additional impairment required under paragraph B of listing 110.07, is the hypotonia or other cause of motor dysfunction. To ensure that the level of severity is understood, the definition is repeated in paragraph B of listing 110.07 of the final rules.

Comment: One commenter indicated that proposed 110.00D (110.00C in the final regulations), which stated that the combined impairments must be evaluated together to determine if they are equal in severity to a listed impairment, was unnecessary because equivalency is inherent in the sequence of evaluation.

Response: We agree with the commenter that equivalency is part of the sequential evaluation process. However, because the listings in 110.00 are somewhat different from the other listed impairments in Part B in that they often involve combinations of impairments, we do not agree that 110.00D is unnecessary. We want to be very clear in explaining that the impairments described in 110.00 rarely involve single physical or mental manifestations and that one shoud not assume that the failure of any single manifestation to meet a listing is the end of the inquiry at the listing level. Children who have the conditions contemplated by final listing 110.07, but who do not meet the listing, may nevertheless have combinations of impairments that are equivalent in severity to listing 110.07.

110.06 Multiple Body Dysfunction

Comment: One commenter noted that there was no mention of the upper age limit which applies to proposed listing 110.06; whereas, in the American Association of Mental Deficiency (AAMD) manual the 18th birthday is given as the upper limit of the developmental period.

Response: In our judgment it is not necessary to state an age limit in the listing itself because §§ 404.1525 and 416.925 of our regulations state that Part B of the Listing of Impairments applies only to the evaluation of impairments of persons under age 18.

Comment: One commenter expressed concern with the format used in proposed listing 110.06 for making reference to other listings and suggested that we revise the format. The commenter indicated that the format in the proposed listing was not consistent with the format of other reference listings in the Listing of Impairments, such as listings 109.09, 104.03, or 12.09.

Response: The comment was adopted in part. With the exception of the format proposed for paragraph B of final listing 110.07, the format is similar to, if not the same as in the other listings cited. We have revised the format of paragraph B of final listing 110.07 to conform with the other listings.

Comment: One commenter requested that we clarify what we meant by "infant" in paragraph A of proposed listing 110.06.

Response: We adopted the comment in part. We have added the phrase "or young child" after the word "infant" to clarify that the term was not meant to exclude the young child. There is no universally accepted definition of infancy according to upper age limit, developmental milestones or activities. For example, "Dorland's Illustrated Medical Dictionary," 26th Edition (W.B. Saunders Co., 1981), defines infancy as the time from the termination of the newborn period (i.e., the first 28 days of life) to the time of assumption of erect posture at 12 to 14 months of age. Some sources make reference to children as "infants" when below the age of 18 months, and thereafter as "children." Others, however, extend infancy to the end of the first 24 months. We are using the phrase "infant or young child" to avoid the situation of having the criteria inadvertently restricted in application to an arbitrary definition based on

chronological age. The criteria can and are meant to be applied to a child of any age where there may be some interference in developmental tasks such as those listed.

Comment: A commenter suggested that since proposed listing 110.06 was not limited to Down syndrome, the listing should also include neurological deficits. The same commenter also suggested that additional examples of age-appropriate developmental activities for young infants, such as following, recognition, and smiling, need to be included.

Response: We agree in part with the commenter's suggestions. We have revised final listing 110.07 to include neurological deficits and have added swallowing, following, reaching, and grasping to the example of age-appropriate major daily or personal care activities. We did not add recognition and smiling in the final listing, even though we agree that they are additional examples of age-appropriate behavior. Normal milestones, in the first year of life, include turning toward stimuli and simple causal mean-ends interactions with the inanimate and animate world. However, recognition and smiling are difficult activities to define and measure. The other age-appropriate major daily or personal activities included in the final listing are easier to define and measure.

Comment: Two commenters considered the format for paragraph B2 of proposed listing 110.06 to be confusing. Both commenters suggested an alternate format. One of the commenters also expressed concern that the two-thirds milestone criteria would complicate adjudication.

Response: The comment was adopted in part. We agree that the format may have been somewhat difficult to understand and have revised it to improve its clarity. However, we believe it is important to have a measurement of milestone performance; i.e., two-thirds of chronological age, which corresponds to an IQ of 60–69 for those infants and young children who cannot be evaluated with standardized intelligence tests. Methods for determining developmental age relative to chronological age, using milestone criteria, have been well established, and the procedure for determining two-thirds age milestones are no different than longstanding procedures for determining one-half age milestones.

Comment: One commenter requested that we include a further explanation of our definition of mental retardation in paragraph B of proposed listing 110.06. The commenter asked how the definition in this listing related to the definition found in the AAMD manual, "Classification in Mental Retardation" (1983).

Response: The comment was not adopted. We believe that the definition in paragraph B of final listing 110.07 is consistent with the definition in the AAMD manual even though the definition in listing 110.07 would not require us to use formal testing where a description of adaptive deficits could be satisfactorily evaluated according to established developmental norms, as indicated in 112.00B. We do not believe that it is necessary to add the requirement of formal testing to the listing and we have not done so in the final rules.

Comment: The same commenter questioned the cutoff IQ score presented in paragraph B of proposed listing 110.06 (i.e., 69) since the AAMD manual and the "Diagnostic and Statistical Manual of Mental Disorders", third edition, revised (DSM–III–R) mention 70 as the upper limit for IQ scores in the range of mental retardation.

Response: The cutoff IQ score of 69 is consistent with other listings in the current Listing of Impairments.

Comment: One commenter raised the question why the standards in proposed listing 110.06 were different than in listing 112.05.

Response: We intended a similar level of severity under paragraph B2 of proposed listing 110.06 as currently exists under paragraph C of listing 112.05. In the final rules, we have revised paragraph B of listing 110.07 to make it clear that the standard under these criteria is consistent with the standard established under paragraph C of listing 112.05 regarding the IQ criterion.

Comment: One commenter indicated that to be consistent with listing 110.02, the wording "growth failure" in paragraph C of listing 110.06 should be changed to "growth impairment."

Response: The recommendation was accepted and the listing had been revised to reflect it.

Comment: The same commenter recommended that to be consistent with the wording in 102.00 the word "impairments" should be substituted for the word "defects" in paragraph D of proposed listing 110.06.

Response: We agree with the recommendation and have made this change.

Comment: One commenter raised the question whether the speech defect described in paragraph D of proposed listing 110.06 included only those speech conditions due to a hearing defect, as required under listing 102.08. The commenter recommended that speech defects attributable to other causes, such as those under listing 111.09, should also be included.

Response: The comment was adopted. We agree that neurological disorders as a cause of speech and language impairments as described under listing 111.09 should be included in addition to those referred to under 102.00. In the final rules we have revised the sentence to read, "Significant interference with communication due to speech, hearing, or visual impairments as described under the criteria in 102.00 and 111.09."

Comment: One commenter noted that in paragraph F of proposed listing 110.06 the reference listing included listing 111.02, major motor seizures, but excluded listing 111.03, minor motor seizures. In the commenter's opinion this did not appear appropriate, and the commenter recommended that we include minor motor seizures in paragraph F of proposed listing 110.06.

Response: The comment was adopted. Multisystem disorders when manifested by seizures are more often associated with the major motor type than the minor motor type. However, we have included minor motor seizures in paragraph F of listing 110.07 in the final regulations.

Regulatory Procedures

Executive Order 12291

The Secretary has determined that this is not a major rule under Executive Order 12291 because the changes we have made will have little, if any, impact on costs. Therefore, a regulatory impact analysis is not required.

Paperwork Reduction Act

These regulations will impose no new reporting or recordkeeping requirements subject to clearance by the Office of Management and Budget.

Regulatory Flexibility Act

We certify that these regulations will not have a significant economic impact on a substantial number of small entities because they primarily affect only individuals who are applying for title II or title XVI benefits based on disability. Therefore, a regulatory flexibility analysis as provided in Public Law 96–354, the Regulatory Flexibility Act, is not required.

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

List of Subjects in 20 CFR Part 404

Administrative practice and procedure, Death benefits, Disability benefits, Old-Age, Survivors and Disability Insurance.

Dated: July 26, 1990.

Gwendolyn S. King,

Commissioner of Social Security.

Approved: October 4, 1990.

Louis W. Sullivan,

Secretary of Health and Human Services.

Part 404 of Chapter III of title 20 of the Code of Federal Regulations is amended to read as follows:

PART 404—[AMENDED]

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

Authority: Secs. 202, 205 (a), (b), and (d)–(h), 216(i), 221 (a) and (i), 222(c), 223, 225, and 1102 of the Social Security Act, as amended; 42 U.S.C. 402, 405 (a), (b), and (d)–(h), 416(i), 421 (a) and (i), 422(c), 423, 425, and 1302; sec. 505(a) of Pub. L. 96–265, 94 Stat. 473; secs. 2(d)(2), (5), (6), and (15) of Pub. L. 98–460, 98 Stat. 1797, 1801, 1802, and 1808.

Appendix 1 to Subpart P—[Amended]

2. Listing 110.00, Multiple Body Systems, of Part B of Appendix 1 (Listing of Impairments), of subpart P is amended by revising the text of paragraphs A and B, by adding a new paragraph C and by adding new listings 110.06 and 110.07 to read as follows:

110.00 Multiple Body Systems

A. This section refers to those life-threatening catastrophic congenital abnormalities and other serious hereditary, congenital, or acquired disorders that usually affect two or more body systems and are expected to:

1. Result in early death or developmental attainment of less than 2 years of age as described in listing 110.08 (e.g., anencephaly or Tay-Sachs); or

2. Produce long-term, if not life-long, significant interference with age-appropriate major daily or personal care activities as described in listings 110.06 and 110.07. (Significant interference with age-appropriate activities is considered to exist where the developmental milestone age did not exceed two-thirds of the chronological age at the time of evaluation and such interference has lasted or could be expected to last at least 12 months.) See 112.00B for a discussion of developmental milestone criteria and evaluation of age-appropriate activities.

Down syndrome (except for mosaic Down syndrome, which is to be evaluated under listing 110.07) established by clinical findings, including the characteristic physical features, and laboratory evidence is considered to meet the requirement of listing 110.06 commencing at birth. Examples of disorders that should be evaluated under listing 110.07 include mosaic Down syndrome and chromosomal abnormalities other than Down syndrome, in which a pattern of multiple impairments (including mental retardation) is known to occur, phenylketonuria (PKU), fetal alcohol syndrome, and severe chronic neonatal infections such as toxoplasmosis, rubella syndrome, cytomegalic inclusion disease, and herpes encephalitis.

B. Documentation must include confirmation of a positive diagnosis by a clinical description of the usual abnormal physical findings associated with the condition and definitive laboratory tests, including chromosomal analysis, where appropriate (e.g., Down syndrome). Medical evidence that is persuasive that a positive diagnosis has been confirmed by appropriate laboratory testing, at some time prior to evaluation, is acceptable in lieu of a copy of the actual laboratory report. Documentation of immune deficiency disease must be submitted and may include quantitative immunoglobulins, skin tests for delayed hypersensitivity, lymphocyte stimulative tests, and measures of cellular immunity mediators.

C. When multiple body system manifestations do not meet one of the established criteria of one of the listings, the combined impairments must be evaluated together to determine if they are equal in severity to a listed impairment.

* * * * *

110.06 Down syndrome (excluding mosaic Down syndrome) established by clinical and laboratory findings, as described in 110.00B. Consider the child disabled from birth.

110.07 Multiple body dysfunction due to any confirmed (see 110.00B) hereditary, congenital, or acquired condition with one of the following:

A. Persistent motor dysfunction as a result of hypotonia and/or musculoskeletal weakness, postural reaction deficit, abnormal primitive reflexes, or other neurological impairment as described in 111.00C, and with significant interference with age-appropriate major daily or personal care activities, which in an infant or young child include such activities as head control, swallowing, following, reaching, grasping, turning, sitting, crawling, walking, taking solids, feeding self; or

B. Mental retardation as evidenced by one of the following:

1. Mental retardation as described in 112.05A, B, or C; or

2. Achievement of only those developmental milestones generally acquired by children no more than two-thirds of the child's chronological age, and a physical or other mental impairment imposing additional and significant restrictions of function or developmental progression; or

C. Growth impairment as described under the criteria in 100.02A or B; or

D. Significant interference with communication due to speech, hearing, or visual impairments as described under the criteria in 102.00 and 111.09; or

E. Cardiovascular impairments as described under the criteria in 104.00; or

F. Other impairments such as, but not limited to, malnutrition, hypothyroidism, or seizures should be evaluated under the criteria in 105.08, 109.02 or 111.02 and 111.03, or the criteria for the affected body system.

* * * * *

[FR Doc. 90-28745 Filed 12-11-90; 8:45 am]

BILLING CODE 4190-29-M

20 CFR Parts 404 and 416

[Regulations No. 4 and 16]

RIN 0960-AB96

Disability Insurance and Supplemental Security Income; Mental Disorders in Children

AGENCY: Social Security Administration, HHS.

ACTION: Final rule.

SUMMARY: These amendments revise the medical criteria in the Listing of Impairments that are used to evaluate mental disorders in children under age 18 for the disability programs in title II and title XVI of the Social Security Act (the Act). The revisions reflect advances in medical knowledge, treatment, and methods of evaluating mental disorders in children and provide up-to-date criteria for use in the evaluation of disability claims based on childhood mental disorders.

These amendments revise the criteria we use when determining whether children's impairments meet or equal the severity of the impairments found in the mental disorders listings. The Supreme Court's February 20, 1990, decision *Sullivan* v. *Zebley et al.*, ____ U.S. ____, 110 S.Ct. 885 (1990), requires us to provide an individual assessment of the functional impact of a child's impairments when the severity of the impairments does not meet or equal the severity of the impairments found in the Listing of Impairments. Since the Court's decision did not preclude the use of the listings as a basis for a decision that a child is disabled, the listings contained in these final rules will be used to determine that a child is disabled based on an impairment that meets or equals the severity of a listed impairment. We currently are developing standards to implement the Supreme Court's decision in *Zebley*. Until these standards are implemented, disability claims filed on behalf of children with impairments will not be denied based only on our finding that the severity of their impairments does not meet or equal the criteria set out in these final rules.

DATES: These rules are effective December 12, 1990.

FOR FURTHER INFORMATION CONTACT: William J. Ziegler, Legal Assistant, Office of Regulations, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235, (301) 965–1759.

SUPPLEMENTARY INFORMATION: The criteria for evaluating the severity of

mental disorders in children are found in 112.00 of Part B of the Listing of Impairments in Appendix 1 of subpart P of part 404 of title 20 of the Code of Federal Regulations (CFR). Appendix 1 is divided into Part A and Part B. The criteria in Part A describe impairments that are severe enough to prevent a person from doing any gainful activity, absent evidence to the contrary. Part B of Appendix 1 contains additional criteria that only apply to the evaluation of impairments of persons under age 18. Part B was initially included only in Appendix 1 of subpart I of part 416 in 1977, subsequent to the enactment of the Supplemental Security Income (SSI) program. While Part B applies mainly to claims by children for SSI benefits based on disability under title XVI of the Act, it also applies to some claims for disability insurance benefits and child's insurance benefits under title II. In recodifying the title II and title XVI disability regulations on August 20, 1980 (45 FR 55566), we took the criteria used in making disability determinations out of part 416 and placed them only in Appendix 1 of subpart P of part 404. This was done to eliminate repetition in the regulations, since the criteria contained in Appendix 1 apply to both the title II and title XVI disability programs. (See 20 CFR 404.1525 and 416.925.).

When parts of the Listing were revised and published in **Federal Register** on December 6, 1985 (50 FR 50068), we indicated in the preamble that medical advancements in disability evaluation and treatment, and our increased program experience would require us to review and update the Listing periodically. Accordingly, we published termination dates ranging from 4 to 8 years for each of the specific body system listings. These dates currently appear in the introductory paragraphs of the Listing; the expiration date for Part B of the listings for mental disorders in children was December 5, 1993. We are now updating the mental disorders listings in 112.00 (Part B) and extending the effective date of these revised listings for 5 years from the date of their publication. We intend to carefully monitor these regulations over the 5-year period by providing ongoing evaluation of the medical evaluation criteria. Therefore, 5 years after publication of the final rules, these regulations will cease to be effective unless extended by the Secretary or revised and promulgated again as a result of the findings from the evaluation period.

These regulations were published in the **Federal Register** (54 FR 33238) as a Notice of Proposed Rulemaking (NPRM) on August 14, 1989. Interested persons, organizations, and groups were invited to submit comments pertaining to the proposed amendments within a period of 60 days from the date of publication of the NPRM. The comment period ended on October 13, 1989. After carefully considering the comments contained in the 145 letters we received regarding the proposed rules, we are adopting the proposed rules with modifications explained later in this preamble.

Explanation of the Final Rules

We have updated the medical terms we use to describe the major mental disorders of childhood, their characteristics, and symptoms to conform to the terminology currently used by psychiatrists, psychologists, pediatricians, and other professionals who treat children who have mental disorders. The terminology we proposed in the NPRM in the **Federal Register** of August 14, 1989 (54 FR 33238) was based on the third edition of the "Diagnostic and Statistical Manual of Mental Disorders" (DSM–III), published by the American Psychiatric Association (APA) in 1980. We have revised these final listings so that they are based on the terminology used in the revised third edition of the "Diagnostic and Statistical Manual of Mental Disorders" (DSM–III–R), published by the APA in 1987. This edition, as the previous edition, gives a common basis for communication, which is particularly important in evaluating medical reports used in determining disability. In most instances, any differences between the terminology in the DSM–III–R and the DSM–III do not have a substance effect on the rules from the way we proposed them; we describe any important changes below and in the "Public Comments" section of this preamble.

The listings are also more specifically related to distinct types of mental disorders. Thus, we have included fewer disorders under the same listing than were grouped together under the former listings. The result is an increase in the number of listings from four to eleven. The organization of mental disorders is based on the DMS–III–R, which provides a more realistic organization in terms of the common characteristics of the mental disorders that are evaluated under a particular listing.

In the NPRM, we proposed to confine the use of the Psychiatric Review Technique to those cases in which we used the criteria of the adult mental listings to evaluate children's claims. However, in response to several public comments, we reconsidered using a technique to assist in the evaluation of claims filed on behalf of children with mental disorders. We are now preparing revisions to the technique and plan to publish these revisions in an NPRM.

We have also revised the terminology used to describe the various age groups. The term "newborn and younger infants" is used to describe children from birth to attainment of age 1, and the term "older infants and toddlers" means children age 1 to attainment of age 3; the term "infants and toddlers" refers to both groups together, that is, from birth to attainment of age 3.

One of the major changes from the NPRM is in the way we will apply the paragraph B criteria. Many public commenters questioned why certain listings required children to meet more of the paragraph B criteria than others. They stated that if the paragraph B criteria represented functional measures of listing-level severity, it should follow that the same number of paragraph B criteria would be disabling under all of the listings. We agree with the commenters and have revised the listings so that all listings that employ paragraph B criteria have the same number of functional requirements.

Another major change in the way we apply the paragraph B criteria is that we will require children aged 3 to attainment of age 18 to meet two of the age-appropriate paragraph B criteria. In some listings, this is an increase from the proposed listings, whereas in others it is a decrease. We explain the reasons for these changes below. Older infants and toddlers, age 1 to attainment of age 3, will have to meet only one of the age-appropriate paragraph B criteria; similarly, final listing 112.12 (proposed listing 112.10), the listing for newborn and younger infants from birth to attainment of age 1, also requires only one criterion.

The final listings also include a significantly revised listing 112.08 and two new listings, which we added in response to numerous public comments. In the NPRM, we proposed a listing 112.08, Personality Disorders, that did not provide specific criteria for the evaluation of these disorders in children. Instead, it was a reference listing to listing 12.08 in Part A of Appendix 1 to subpart P of the Regulations No. 4, the adult listings. In response to comments, we have replaced the reference listing with a complete listing, which includes paragraph A and paragraph B criteria specific to children.

We also agreed with the many commenters who urged us to add new listings for psychoactive substance dependence disorders (final listing

112.09) and attention deficit hyperactivity disorder (final listing 112.11). We describe both of these listings in the summary below and address the public comments in the public comment section of this preamble. We have renumbered two of the listings to reflect the addition of these two new listings. Autistic Disorder and Other Pervasive Developmental Disorders, proposed as listing 112.09, is now final listing 112.10, and Developmental and Emotional Disorders of Newborn and Younger Infants (originally called "Developmental and Emotional Disorders of Infancy" in the proposed rules at 112.10) is now listing 112.12.

The following is a summary of the listings we are adopting in these final rules and some of the more extensive changes we have made from the text of the proposed rules. We describe other changes in the public comments section of this preamble.

112.00 Preface

In 112.00A of the preface, Introduction, we explain the basic approach used in the listings. In this section, we explain that each listing begins with an introductory statement (capsule definition) that describes the disorder or disorders addressed by the listing. If a child has a mental disorder described by this capsule definition, the listing is used to evaluate the disorder to determine whether the child "meets" the listing. Most of the listings then continue with a dual approach, which divides each listing into two paragraphs. The first paragraph (the paragraph A criteria) describes the characteristics necessary to substantiate the existence of a listed mental disorder, while the second paragraph (the paragraph B criteria) describes the applicable restrictions and functional limitations which may result from the disorder in children and the number of paragraph B criteria needed to satisfy the severity requirement of the listing.

In response to public comments, we have added a new paragraph at the end of 112.00A to emphasize that the impairments in the listings are examples of some of the most common disabling mental disorders that may affect children. The new paragraph provides that when a child has a medically determinable impairment that is not listed or a combination of impairments, no one of which meets a listing, we will make a medical equivalency determination in accordance with §§ 404.1526 and 416.926 of our regulations.

In 112.00B of the preface, Need for Medical Evidence, we describe the need for medical evidence to substantiate the existence of a medically determinable impairment. Although we have not made any substantive changes in this paragraph, we have revised the first sentence so that it contains language that is the same as language in §§ 404.1525, 404.1526, 404.1528, 416.925, 416.926, and 416.928 of our regulations. The change is intended to clarify our meaning of the term "laboratory findings" and to make the language of the listings consistent with the regulations.

In 112.00C of the preface, Assessment of Severity, we describe in detail the multiple factors in the paragraph B criteria of listing 112.02 which we use for assessing the degree of functional limitations required to meet the severity of the listing in various age groups in children. We reorganized the text and made several changes to clarify terminology; we describe these changes in the public comments section. We also made several additions in response to public comments. These additions are intended to provide further detail on the importance of parents and others as sources of information about a child's day-to-day functioning in medical evaluations of mental disorders and in our adjudications of the cases. Other revisions provide specific detail about sources of evidence of the various areas of functioning at different age levels. Related to these additions is an important change of terminology. We have replaced the word "clinical" with the word "medical" in this section and throughout the remainder of the preface and the listings to underscore our intent that all determinations, including those that ultimately rely on the results of standardized testing, must be based on consideration of all medical evidence, which generally incorporates information supplied by parents and others. We provide a detailed explanation for this change, including why we chose the word "medical," in our responses to the public comments.

Finally, we have added a statement in the second paragraph to explain that older infants and toddlers (that is, children from age 1 to attainment of age 3) may present the same problems of diagnosis as younger infants because of insufficient developmental differentiation. When such children have impairments that do not meet the listings, we will consider whether the impairments are equivalent to any listed impairment, including the impairments in listing 112.12 when appropriate to the particular facts of a child's case.

In 112.00D of the preface, Documentation, we discuss the evidence needed to document mental disorders in children. In the final rules, we have expanded the first paragraph to include discussion of the importance of evidence from parents and other sources who have knowledge of a child's day-to-day functioning in medical evaluations and in our adjudications. Beginning with the seventh paragraph, we have added more detail about the use of standardized testing, including a new tenth paragraph which codifies our longstanding policies on how long IQ test results remain valid at different ages. A new eleventh paragraph specifies that standardized intelligence tests are essential to adjudications under final listings 112.05C, D and E, and that listings 112.05A, B, and F provide alternatives to testing. In the 16th paragraph, we have incorporated additional detail on the evaluation of children whose principal language is not English; these are also longstanding policies. Throughout 112.00D we have also added references to pediatricians as expert sources of evidence about children's mental disorders.

In 112.00E, Effect of Hospitalization or Residential Placement, and 112.00F, Effects of Medication, we explain that evaluation of mental disorders in children must include consideration of the fact that medications, hospitalizations, and other highly structured living arrangements may minimize the overt indications of severe, chronic mental disorders without necessarily affecting the functional limitations imposed by the disorder. Section 112.00F also acknowledges that medications may sometimes produce side effects that add to the functional limitations resulting from mental disorders in children. The only change we have made from the language we proposed for both of these sections is the addition of a sentence at the end of the first paragraph of 112.00E, to provide more guidance on how to assess functional impairment when structured settings ameliorate the overt indications of a mental disorder.

112.02 Organic Mental Disorders

We incorporated ten factors that are characteristic of organic mental disorders in children in the paragraph A criteria of the final listing; this is one more criterion than we proposed in the NPRM. We have also revised the language of the capsule definition to incorporate the description we had originally proposed as the opening statement to the paragraph A criteria and to make the capsule definition consistent with the DSM-III-R. In paragraph A, we have provided more

examples of medical findings associated with the various A criteria.

Paragraph B contains the restrictions or functional limitations used to assess the severity of these disorders and, by reference, the disorders is most of the other listings. Mental disorders do not manifest themselves in the same way in children of different ages. Therefore, paragraph B provides criteria for the assessment of impairment severity for two age groups, "older infants and toddlers," age 1 to attainment of age 3, and "children," age 3 to attainment of age 18.

The criteria used to assess impairment severity in older infants and toddlers (age 1 to attainment of age 3) are based upon functional deficits in the following areas: Gross and fine motor development, cognitive/communicative function, and social functioning. The criteria used to assess impairment severity in children (age 3 to attainment of age 18) are based upon functional deficits in the following areas: Cognitive/communicative function, social functioning, personal/behavioral function, and concentration, persistence, and pace.

The criteria in paragraph 112.02B1 recognize the difficulty of assessing specific areas of functional impairment in older infants and toddlers. Therefore, each of the first three criteria under this paragraph is based on a comparison of a child's functioning in one of the major milestone domains with children who are one-half the child's chronological age. We believe that a disorder of such functional impact in a child age 1 to attainment of age 3 is sufficient to establish listing-level severity and have, therefore, provided that when an older infant or toddler, age 1 to attainment of age 3, demonstrates functional deficits or restrictions in one of the first three areas to the degree specified in the paragraph B1 criteria, the child will satisfy the requirements of listing 112.02. We have also provided a fourth criterion which states that a child who is somewhat less impaired in the major milestone domains, but who demonstrates this lessor degree impairment in at least two of the major milestone domains, will be found to be disabled.

We have revised the language of paragraph 112.02B1 to replace the language "50 percent or less of the anticipated developmental norm," with the more straightforward language "generally acquired by children no more than one-half the child's chronological age," in the first three B1 criteria; this is not a change in meaning, but a clarification of our intent.

We have made an important change in paragraph 112.02B2. A number of commenters pointed out that there were inconsistencies in the proposed rules, especially in the number of paragraph B criteria applied throughout the listings. As we have already stated, we agree with the comment that the functional criteria should be uniform, that is, that each listing should require the same number of paragraph B criteria.

Five commenters asked us to adopt a system whereby a child with "marked" impairment of functioning in two of the domains of the paragraph B criteria, or "extreme" impairment in one domain, would meet the severity level of the listings. The commenters stated that this was the "clinically appropriate" solution and that it would " render the listings in harmony with professional opinion."

In a different context, though clearly relevant, the American Psychiatric Association (APA) has provided professional support for this position in connection with its study of our adult mental criteria. The APA concluded that the usefulness of functional domains, each of which taps complex phenomena, is enhanced by requiring demonstrated impact in more than just one domain. We believe that, although the functional domains for children age 3 to attainment of age 18 are not identical to those for adults, there is some overlaps and they do tap similarly complex phenomena.

Furthermore, when we compared the paragraph B1 criteria (that is, the criteria for older infants and toddlers, age 1 to attainment of age 3) with the paragraph B2 criteria (the criteria for children age 3 to attainment of age 18) we realized that we had proposed inconsistent systems of rating function at the two age levels. In paragraph B1 we had, in effect, proposed a system very much like the system the five commenters proposed. That is, the first three criteria, requiring milestones of 50 percent of the expected norm in any of the functional domains, described such functional impairment that they could be characterized as extreme, and any one of them in an older infant or toddler could alone establish disability. This was underscored by our fourth criterion in paragraph B1, which recognized that a child who was somewhat less impaired in two of the three domains—which means a combination of two paragraph B criteria at the marked level—would be disabled.

On the other hand, the paragraph B2 criteria were not based on measurable milestones but were based on a standard of "marked" impairment. It was clear to us that it would have been inconsistent with the scheme in paragraph B1 to provide that a marked impairment in only one functional domain would meet the severity of the listing; perhaps more importantly, it would have contradicted our intent in placing the term " marked" on a continuum between moderate and extreme, that is, that a child's impairment could meet or equal the severity of a listed impairment without being profoundly debilitated.

Therefore, we decided to require that children age 3 to attainment of age 18 would have to meet two of the paragraph B criteria. We believe that our decision is consistent with the APA's research findings about the adult paragraph B criteria, that it is " clinically appropriate" and that it will make our listings internally consistent and more understandable. We further believe that this change will clarify that the requirements in listing 112.02B2 are comparable to the requirements in listing 112.02B1d and thus provide a more realistic frame of reference for the evaluation of functional impairment in children for both age groups.

112.03 Schizophrenic, Delusional (Paranoid), Schizoaffective, and Other Psychotic Disorders

This listing groups psychotic disorders that are more closely related than in the former listing. Mood disorders are to be evaluated under listing 112.04.

In the final listing, we have revised the title, capsule definition, and the paragraph A criteria to reflect DSM–III–R terminology. In the new NPRM, we had proposed requiring that there be an abnormality of affect (blunt, flat, or inappropriate affect) associated with signs of disrupted thought (incoherence, loosening of associations, illogical thinking, or poverty of content of speech) under criterion 112.03A3. In final paragraph 112.03A4, we have made abnormal affect a separate paragraph A criterion, consistent with DSM–III–R criteria.

To fulfill the requirements of listing 112.03, it must be demonstrated that an older infant or toddler, age 1 to attainment of age 3, who satisfies the paragraph A criteria also has functional deficits or restrictions in one of the areas to the degree specified in the criteria of listing 112.02B1; a child, age 3 to attainment of age 18, must demonstrate functional deficits or restrictions specified in two of the areas in listing 112.02B2.

112.04 Mood Disorders

We have changed the title (from "Affective Disorders") to reflect current terminology. We have also revised the

capsule definition and the paragraph A criteria of each of the three types of syndromes in the listing to be consistent with the DSM–III–R and to provide criteria that are specific to these disorders in children

In the former organization of the childhood mental listings, mood disorders were evaluated under listing 112.03 ("Psychosis of Infancy and Childhood") or listing 112.04 ("Functional Nonpsychotic Disorders"). The new listing includes only those disorders that are characterized by a disturbance of mood. In paragraph A of the listing, we describe the characteristics of mood disorders in much greater detail than they were described in the former listings.

To fulfill the requirements of listing 112.04, it must be demonstrated that an older infant or toddler, age 1 to attainment of age 3, who satisfies the paragraph A criteria also has functional deficits or restrictions in one of the areas to the degree specified in the criteria of listing 112.02B1; a child, age 3 to attainment of age 18, must demonstrate functional deficits or restrictions specified in two of the areas in listing 112.02B2.

112.05 Mental Retardation

Listing 112.05 now contains six separate paragraphs instead of the three in the former listing, any one of which is a basis for meeting the listing. In response to public comments, we have revised the language of paragraph A; however, it remains the same in concept as former listing 112.05A. Instead of using the less specific reference to developmental milestones of the former listings, we now assess the functional impact of mental retardation in the specific functional domains of listing 112.02B.

Paragraph B contains a new set of criteria patterned after adult listing 12.05A. These criteria are applicable when the child requires assistance for personal needs which is grossly in excess of what is ordinarily expected and the use of standardized IQ testing is precluded.

Paragraph C is the former paragraph B and remains unchanged. Paragraph D corresponds to paragraph C of the former listing; the only significant change is that we have increased the upper IQ limit from 69 to 70 to accord with the upper limit of mild mental retardation in the DSM–III–R. (We have changed all other references in Parts A and B of these listings to conform to this change. See the descriptions of "Other Changes" at the end of this preamble.)

Paragraph E corresponds to proposed paragraph D and was not a part of the former listings. It provides an alternative to the assessment of children with IQ's of 60 through 70. Instead of requiring a coexisting physical or mental impairment, listing 112.05E can be met with specified levels of dysfunction in the domains of listing 112.02B.

Paragraph F is new. We added it in response to comments that pointed to new rules for evaluating children with serious hereditary, congenital or acquired disorders that we had proposed in a separate notice and subsequently published as listing 110.07B2.

Paragraph F of listing 112.05 provides another alternative to paragraph D. It is to be used when a child has mental retardation which coexists with another physical or mental impairment but valid IQ test results are lacking. Instead of demonstrating an IQ of 60 through 70, the child must demonstrate a specified level of dysfunction in the cognitive/communicative domains of 112.02B; the specified level corresponds to developmental milestones normally attained by children who are two-thirds of a child's chronological age.

We have also deleted the discussion about standardized testing we proposed in the opening paragraph of 112.05. As we explain in greater detail in the responses to public comments, we have provided clearer and more comprehensive discussions in 112.00D in lieu of the statement we proposed to head the listing itself. Finally, we have made minor editorial revisions throughout the listing.

112.06 Anxiety Disorders

We have revised the title (from "Anxiety-Related Disorders") to reflect current DSM–III–R terminology. In the former organization of the listings, anxiety disorders were grouped with similar mental disorders in a single listing (112.04). New listing 112.06 exclusively covers disorders related to anxiety. Items 3, 4, and 6 in paragraph A of this listing are similar to items covered in the former listing. New paragraph A1 gives significance to separation anxiety. New paragraph A2 gives significance to avoidance behavior of childhood. New paragraph A5 gives significance to frequent panic attacks. New paragraph A7 provides for the inclusion of anxiety disorders resulting from traumatic experiences. We have also made revisions to the capsule definition and the third and fifth A criteria to update the terminology consistent with the DSM–III–R and to make the listing more comprehensive.

As in listings 112.02, 112.03, and 112.04, an older infant or toddler, age 1 to attainment of age 3, who satisfies the paragraph A criteria will fulfill the requirements of listing 112.06 by demonstrating functional deficits or restrictions in one of the areas to the degree specified in the paragraph B1 criteria of listing 112.02; a child, age 3 to attainment of age 18, must demonstrate functional deficits or restrictions specified in two of the areas in paragraph B2 of listing 112.02.

112.07 Somatoform, Eating, and Tic Disorders

These disorders were previously evaluated along with nonpsychotic disorders under former listing 112.04. The new listing now includes under one heading various mental disorders which have physical manifestations. To make this fact clear, we have revised the title and the capsule definition from the language we proposed in the NPRM to state more explicitly the kinds of impairments that are to be evaluated under this listing. We have also revised paragraph 112.07A1, the criterion for eating disorders, to provide more specific guidance for the evaluation of certain eating disorders; this includes a reference to average weight tables for children in the most recent edition of the "Nelson Textbook of Pediatrics", Richard E. Behrman and Victor C. Vaughan, III, editors, Philadelphia: W. B. Saunders Company.

As in most other listings in this section, an older infant or toddler, age 1 to attainment of age 3, who satisfies the paragraph A criteria will fulfill the requirements of listing 112.07 by demonstrating functional deficits or restrictions in one of the areas to the degree specified in the paragraph B1 criteria of listing 112.02; a child, age 3 to attainment of age 18, must demonstrate functional deficits or restrictions specified in two of the areas in paragraph B2 of listing 112.02.

112.08 Personality Disorders

These disorders were previously evaluated under listing 112.04. In the NPRM, we proposed a reference listing which referred the evaluator to listing 12.08 of the adult mental disorders listings in Part A of the Listing of Impairments. We reasoned that reference to the adult listings was appropriate because personality disorders do not usually manifest themselves until later in childhood.

We received many comments urging us to include a specific listing for personality disorders in children. Some commenters pointed out that mental disorders that affect both children and adults do not necessarily manifest themselves in the same way in children

as they do in adults. Almost all of the commenters also pointed out that even if the paragraph A criteria of adult listing 12.08 were applicable to children, the adult paragraph B criteria would rarely be applicable because two of those criteria are work-related.

Because we agree with the commenters that there will be only rare cases in which it will be appropriate to use any of the adult mental disorders criteria, we have replaced the proposed reference listing with a listing for children. The listing contains a full complement of paragraph A and paragraph B criteria. We have not, however, adopted all of the public recommendations for the criteria we should include in the listing; we provide responses to specific comments later in the public comments section of this preamble.

Final listing 112.08 provides a capsule definition based on the DSM-III-R definition, but tailored specifically to children. There are seven paragraph A criteria, six of which are the same as the paragraph A criteria of adult listing 12.08; the seventh is a new criterion which incorporates obsessive compulsive personality disorder into the listings.

The functional criteria are the same as in most of the other childhood mental disorders listings. An older infant or toddler, age 1 to attainment of age 3, who satisfied the paragraph A criteria will fulfill the requirements of listing 112.08 by demonstrating functional deficits or restrictions in one of the areas to the degree specified in the paragraph B1 criteria of listing 112.02; a child, age 3 to attainment of age 18, must demonstrate functional deficits or restrictions specified in two of the areas in paragraph B2 of listing 112.02.

112.09 Psychoactive Substance Dependence Disorders

We have added this new listing in response to numerous public comments with which we agreed. We have redesignated proposed listing 112.09, originally assigned to autism and other pervasive developmental disorders in the proposed rules, to 112.10 in the final rules, so that the numerical designation for the childhood listing for psychoactive substance dependence disorders (112.09) will correspond to the adult listing for these disorders (12.09).

The new listing is based on criteria for psychoactive substance dependence in the DSM–III–R. However, we have consolidated several of the criteria in the DSM–III–R so that we have six paragraph A criteria. We did this to eliminate some overlap in the DSM–III–R criteria.

A child will satisfy paragraph A of the listing if he or she demonstrates at least four of the specified paragraph A criteria. As in most of the other listings, an older infant or toddler, age 1 to attainment of age 3, will fulfill the requirements of listing 112.09 by demonstrating functional deficits or restrictions in one of the areas to the degree specified in the paragraph B1 criteria of listing 112.02; a child, age 3 to attainment of age 18, must demonstrate functional deficits or restrictions specified in two of the areas in paragraph B2 of listing 112.02. If a child does not meet the listing because he or she does not satisfy the specific paragraph A criteria—as, for instance, might happen if the child has a substance abuse rather than a substance dependence disorder—the child will generally still be evaluated under this listing to determine whether he or she has an impairment equivalent in severity and duration to this listing.

The listing is not intended for the evaluation of children who have fetal alcohol syndrome (FAS) or other similar psychoactive substance syndromes. Because these impairments typically involve more than one body system, children who are born with FAS or other such syndromes will be evaluated under listing 110.07 which includes specific criteria for evaluating these impairments.

112.10 Autistic Disorder and Other Pervasive Developmental Disorders

In the final listings, we have revised the number designation from proposed 112.09 to final 112.10 because we assigned listing 112.09 to the new psychoactive substance dependence disorders listing. We have also revised the title, capsule definition and the paragraph A criteria to be consistent with the DSM–III–R. The former listings did not specifically include autistic disorder and other pervasive developmental disorders. Instead, the disorders were evaluated under listings 112.02, 112.03, or 112.05, depending on the individual facts of the case.

The final listing requires an autistic child to demonstrate qualitative deficits in all three of the following areas: Social interaction, verbal and nonverbal communication and imaginative activity, and repertoire of activities and interests. Children with other pervasive developmental disorders are required to demonstrate qualitative deficits in only the first two of the areas. Because the DSM–III–R lists so many examples under each of these categories, we decided to list only the broad categories as paragraph A criteria in order to avoid giving the impression that we would disregard any appropriate findings.

As in most other listings in this section, an older infant or toddler, age 1 to attainment of age 3, who satisfies the paragraph A criteria will fulfill the requirements of listing 112.10 by demonstrating functional deficits or restrictions in one of the areas to the degree specified in the paragraph B1 criteria of listing 112.02; a child, age 3 to attainment of age 18, must demonstrate functional deficits or restrictions specified in two of the areas in paragraph B2 of listing 112.02.

112.11 Attention Deficit Hyperactivity Disorder

We have added a new listing for the evaluation of children with attention deficit hyperactivity disorder (ADHD). One of the most frequent public comments was that we should have included a separate listing for ADHD, a category that was recommended by experts that helped us to formulate the proposed revisions. We omitted the listing from the NPRM because, as several commenters pointed out, only a minority of children with ADHD will be disabled, and we thought that the children who were disabled because of ADHD could be found to have an impairment that equalled one of the listings we proposed. However, in reconsidering the matter in light of the public comments, we agree with the commenters who stated that children with ADHD comprise a well-defined group, and that the specific guidance of a listing will ensure the most fair, accurate, and uniform adjudications possible. We summarize the specific comments and provide our responses later in this preamble.

The language of the capsule definition and the paragraph A criteria in new listing 112.11 are nearly identical to the experts' proposal. The major difference between the final rule and the experts' proposal is that the capsule definition in the experts' proposal stated that the disorder had to be manifested in a school setting. Since we recognize that some children who are not in school may have the disorder, we have not included this language in the final rule. We have also ensured that the terminology of the listing is consistent with the DSM–III–R. The criteria in the new listing, however, are less specific and, therefore, somewhat broader than the DSM–III–R criteria. They provide that a child who demonstrates developmentally inappropriate inattention, impulsiveness, and hyperactivity to a marked degree will

satisfy the paragraph A criteria of the listing.

As in most other listings in this section, an older infant or toddler, age 1 to attainment of age 3, who satisfies the paragraph A criteria will fulfill the requirements of listing 112.11 by demonstrating functional deficits or restrictions in one of the areas to the degree specified in the paragraph B1 criteria of listing 112.02; a child, age 3 to attainment of age 18, must demonstrate functional deficits or restrictions specified in two of the areas in paragraph B2 of listing 112.02.

112.12 Developmental and Emotional Disorders of Newborn and Younger Infants (Birth to Attainment of Age 1)

The former listings provided only minimal guidance for the special problems of evaluating developmental and emotional disorders in children from birth to attainment of age 1, who often have not developed sufficient personality differentiation to permit formulation of appropriate diagnoses. This new listing provides such guidance, including criteria for evaluating functional loss in all infants of this age group.

Because we added two new listings at 112.09 and 112.11, we have revised the number designation of the final listing from proposed 112.10 to final 112.12. We have also revised the title to incorporate our new terminology for describing infants from birth to attainment of age 1 and made minor editorial changes for the sake of clarity and in response to a public comment that we summarize later in the public comments section. The only substantive change from the proposed rule is that we have added a fifth criterion to reflect the new rules in paragraph B1d of listing 112.02. As in paragraph B1d in listing 112.02, new paragraph E of listing 112.12 provides that a newborn or younger infant may be found to meet the severity of the listing when he or she has attained development or function generally acquired by children no more than two-thirds of the child's chronological age in two or more of the following areas: cognitive/communicative, motor, and social.

Explanation of Changes to Regulations §§ 404.1520a and 416.920a

We are amending §§ 404.1520a(a) and 416.920a(a) to provide that the special procedure described in those regulations must be applied to persons under age 18 when Part A of the Listing of Impairments is used to evaluate mental impairments in these persons.

Public Comments

Subsequent to the publication of the NPRM in the Federal Register (54 FR 33238) on August 14, 1989, we mailed copies to organizations, associations, and other professionals whose responsibilities and interests require them to have some expertise in the evaluation of mental impairments in children. We also sent copies to State agencies (including State disability determination services), national organizations, and other parties interested in the administration of the title II and title XVI disability programs. As part of our outreach efforts, we invited comments from national organizations representing people who are mentally ill, advocates of people who are mentally ill, and service providers. We also invited comments from various health and medical associations, as well as from law and legal service organizations.

We received 145 letters containing comments pertaining to the changes we proposed. The majority of the comments were from organizations and groups that represent people interested in specific mental impairments. Many were from sources with specialized backgrounds in psychiatry, psychology, pediatrics, and other specialties involving childhood mental health. Many of the comments concerned the specific evaluation criteria for the proposed listed mental disorders. Other comments questioned the reasons for not including other childhood mental disorders in the Listing of Impairments.

We have carefully considered the comments and have adopted many of the recommendations. We provide our reasons for adopting or not adopting the recommendations in the summaries of the comments and our responses below. A few of the comments, however, pertained to Social Security matters that were not within the purview of the proposed regulations. We have referred these comments to the appropriate components of the Social Security Administration; therefore, we have not addressed them in this preamble.

A number of the comments were quite long and detailed. Of necessity, we had to condense, summarize, or paraphrase them. However, we have tried to express everyone's views adequately and to respond to all of the relevant issues raised by the commenters.

Finally, several of the commenters referred to the recommendations of the experts that helped us to prepare the proposed listings, and we refer to these experts in our responses below in the same terms. The experts are almost the same as those medical, legal, and other professionals who helped us to prepare the adult mental listings published in August 1985.

General Comments

Comment: Several commenters pointed out that the proposed listings were based on the DSM-III, but that this manual had been replaced by the DSM-III-R. The commenters urged us to reevaluate carefully the proposed listings to make sure that they were completely compatible with the revised manual.

Response: We adopted the comment. We have carefully reevaluated the terminology and criteria of the proposed listings and have made revisions to update the language of the final listings.

Comment: Several commenters offered examples of specific disorders in the DSM-III-R that were not in the listings. Some of these commenters also noted that we had not included all of the DSM-III and DSM-III-R diagnostic criteria for the impairments that were in the listings. Some recommended specific signs and symptoms for inclusion in several of the listings; one commenter systematically catalogued examples of omissions in each of the listings.

Response: The listings are not intended to be all encompassing; rather, they are examples of some of the most common major childhood mental disorders. However, we have tried to accommodate as many of the recommendations as possible, and have made substantial additions and revisions in the final listings. These include the addition of two new listings categories, psychoactive substance dependence disorders (112.09) and attention deficit hyperactivity disorder (112.11), as well as a specific listing for personality disorders instead of the reference to adult listing 12.08 we had originally proposed. We have also revised and expanded the capsule definitions of final listings 112.02, 112.03, 112.04, 112.06, 112.07, 112.08, and 112.10, and many of the paragraph A criteria throughout the listings in response to the comments. However, it is not the purpose of the listings to include all mental impairments or every sign and symptom listed in the DSM-III-R. This does not mean that a child who has an unlisted impairment cannot be found to be disabled with use of the listings. Such a child will be found disabled if his or her impairment(s) is medically equivalent to a listed impairment.

Comment: One commenter questioned the appropriateness of the DSM-III as the basis of these listings. The commenter supported the direction we took in incorporating DSM-III diagnostic

categories in the rules, but expressed the opinion that this standard should not be considered the best or the only source for evaluating mental disorders in children. The commenter urged us to be flexible and to provide our adjudicators with the most reliable and equitable methods for determining mental disability in children.

Response: We believe that we have provided the most reliable and equitable methods for assessing mental disability in children. We chose the DSM–III, and now the DSM–III–R, as the source of the categories and terminology in our listings because, based upon our experience with thousands of claims involving childhood mental impairments, it was the most widely used and accepted resource in the psychiatric and psychological communities. The experts, which included a pediatrician and specialists in the treatment of mental disorders in children, concurred. Also, as demonstrated by the previous comment, most commenters who addressed this issue not only supported our use of the DSM–III DSM–III–R, but urged us to include more terminology and criteria from the manual. Nevertheless, our main interest is in providing the most current, useful and widely understandable rules we can; therefore, we will remain flexible and consider other accepted sources as appropriate in the future.

Furthermore, we want to stress that the DSM–III–R was not the source of our rules on determining severity. We, with the assistance of the experts, devised the crucial rules in 112.00 for the evaluation of mental impairments, and established the functional criteria for listing-level severity in 112.00 and the listings. We used the DSM–III–R only for the descriptions of the impairments and categories of impairments in the listings. We adopted its terminology and categories as a convention for determining and classifying the existence of common mental disorders in children—that is, as the source of our capsule definitions and paragraph A criteria—because it is widely used, widely accepted, and familiar to most professionals who deal with mental impairments. Moreover, we believe that even those professionals who rely on or give greater credence to other manuals are nevertheless generally aware of the DSM–III–R criteria, whereas the converse is not always true.

Comment: One commenter stated that the DSM–III was developed by psychiatrists and was most frequently used by psychiatrists. The commenter noted that other medical specialists, such as pediatricians, did not contribute to the manual. The commenter stated that the criteria in the DSM–III were not used as a norm by other professionals, including nonpsychiatrist clinicians and "SSI disability adjudicators."

Response: Although the comment may have been somewhat true of the DSM–III (there were, in fact, psychologists involved in the drafting), the advisory committees that prepared the DSM–III–R were composed of professionals with varying backgrounds, including psychologists, educators, and a doctor of social work. Furthermore, virtually all of the diagnostic terms of the DSM–III were included in 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; the DSM–III–R maintained consistency with the ICD–9–CM. As we stated in the last response, we believe that the DSM–III–R is very widely used, its terminology well-known, and that it is used by many professionals besides psychiatrists.

We disagree with the comment about "SSI disability adjudicators." These individuals are either employed by State agencies who make disability determinations for us using our rules or work directly for us. They are required by sections 221(a) and 1633 of the Act to use evaluative criteria we provide through regulations (including these listings), rulings, and internal operating instructions. Therefore, we provide the rules used by SSI disability adjudicators.

Comment: Many advocates of the rights of mentally impaired people commented that the listings did not include all impairments from which a child might suffer. The commenters recommended that we provide a "catchall" listing, which would include all impairments that were not included in the other childhood mental listings. The commenters stated that the law requires us to consider "any" impairment that could cause a child to be disabled, but that the listings approach results in our overlooking many medically determinable impairments or denying the claims of those children who do not have impairments that specifically "meet" the listings. One commenter recommended that a catchall listing should also include children with combinations of impairments, no one of which meets a listing; the commenter also suggested that such a listing would serve to keep the childhood mental listings up-to-date, because any currently recognized impairment would automatically be included. Many commenters also suggested that we could make clear in our rules that the listings are only examples of impairments that could make a child disabled.

In related comments, many of the same commenters stated that our policies on determining equivalency were inadequate to assess the impairments of all disabled children, that we do not provide an individualized assessment of the impairments of those children who do not meet or equal the listings, and that we should revise the disability rules to provide for a determination of residual functional capacity in the case of every child who does not have an impairment or combination of impairments that meets or equals the listings. Some commenters asserted, moreover, that we frequently deny the cases of children who do not have impairments that meet the listings. One group stated that they had often represented children with severe functional impairments that did not meet or equal the listings even though the children were nonetheless in their opinion disabled.

Response: We have not adopted the recommendation to add a generic, all-inclusive listing; however, we have provided additional text in 112.00A regarding the importance of equivalency determinations and clarified that the listings are examples of impairments that could disable a child. In addition, we are currently developing standards to implement the Supreme Court's decision in *Sullivan* v. *Zebley et al.* These new standards will provide guidance on how to evaluate the functional impact of children's impairments when the severity of their impairments does not meet or equal the severity of a listed impairment.

Our intent in revising these listings and in issuing all of our listings is to provide specific examples of some of the most common mental impairments upon which we will find a child disabled. The listings are not a list of every possible mental disorder that a child might have. This does not mean that we do not consider impairments that are not listed. Our policy of equivalency is intended to provide an assessment of claims filed on behalf of children with any impairments.

In addition, we have made it clear in the revisions to the final listings and in the responses we give below that individualized assessment is vital to the proper use of these rules. We have emphasized that direct observation by professionals and, in most cases, evidence from parents and others who are aware of a child's day-to-day functioning are critical to the evaluation of mental disorders in children. We have

also provided paragraph B criteria that are based on functioning over time, again a determination that must be made individually in each case. We believe that the kind of comprehensive guidance we have provided within these listings and their introductory paragraphs, especially the detailed guidance we have provided on case development and the assessment of functional impairment, is an appropriate response to some of the problems raised by the commenters.

Although we have not adopted the recommendation to add a generic, all-inclusive listing for children age 1 and older, we recognize in these final rules, as in the proposed rules, the need for such a listing for newborn and younger infants (birth to attainment of age 1). The reason is that it is often difficult, if not impossible, to permit a specific and appropriate diagnosis for newborn and younger infants. Therefore, we believe that a general listing is necessary to evaluate these difficult cases.

Even though the listings do not specifically name every impairment, we believe that with the addition of listings for psychoactive substance dependence disorders and attention deficit hyperactivity disorder, and the other additions and revisions to the final listings we have made in response to public comments, the listings relate to the vast majority of children who have mental impairments. Those children who have mental disorders that are not described by these listings—whether because their impairments are not listed or because they have combinations of impairments, no one of which meets a listed impairment—will have their cases evaluated to determine whether their impairments are medically equivalent to any listed impairment.

To underscore our commitment, we have added language in the last paragraph of 112.00A stressing and restressing the importance of equivalency determinations. We have provided, both at the beginning and the end of the paragraph, that adjudicators must assess equivalency in any case in which a finding cannot be made that a child has an impairment that meets a listing. In direct response to one of the recommendations, we have also provided that the disorders in the listings are examples of impairments which are severe enough to find a child disabled.

Comment: Several commenters asked about our statements in the NPRM regarding the use of the Psychiatric Review Technique Form (PRTF) to evaluate children. Most commenters expressed support for the PRTF and recommended that we consider developing a separate form for use with children.

Response: As we explained in the summary at the beginning of this preamble, we agree with the commenters and we will be proposing a new PRTF and revisions to §§ 404.1520a and 416.920a. When we wrote our explanation in the NPRM, we had in mind the PRTF, that is, the form we now use to evaluate mental disorders in adults. Since the form contains only the adult mental criteria, it is clearly not useful for the vast majority of evaluations under these new listings. Nevertheless, in those rate instances in which the adult listings will apply to children we will require adjudicators to complete an adult PRTF. We have revised the language in these rules to clarify that the technique is applicable to children only when Part A of the Listing of Impairments is used to evaluate their impairments.

112.00A Introduction

Comment: One commenter who was familiar with the experts' proposals asked why the fourth sentence of the second paragraph of 112.00A used only one example instead of the three examples the experts proposed. The commenter suggested that our intent was to narrow the types of clinical behavior on which adjudicators should focus and reduce the weight to be assigned to findings that could have grave prognostic implications.

Response: This was certainly not our intent. On the contrary, our intent was to strengthen the sentence. The original sentence proposed by the experts stated that findings such as separation anxiety, failure to mold or bond with parents, and withdrawal "may have grave prognostic implications and may be comparable in severity to the findings that mark mental disorders in adults." In contract, the sentence we proposed stated that the finding of failure to mold or bond with parents "has grave prognostic implications and serves as a finding comparable in severity to the findings that mark mental disorders in adults." Our intent, therefore, was to give one imperative example (failure to mold or bond is a grave prognostic finding) instead of three conditional examples that might or might not apply and, therefore, did not provide useful, concrete guidance.

Upon further consideration, however, we have realized that any discussion of severity is out of place in the second paragraph of 112.00A. The simple intent of the paragraph is to explain that the signs and symptoms of mental disorders in children can be different from those that define mental disorders in adults; we believe this is clear from the third sentence in the paragraph, which states that the "presentation of mental disorders in children . . . may be subtle and of a character different from the signs and symptoms found in adults." Therefore, in response to the comment we have revised the fourth sentence to include the three examples proposed by the experts, but to make the examples consistent with the intent of the paragraph we have also deleted the language about their severity. The revised sentence now reads: "For example, findings such as separation anxiety, failure to mold or bond with the parents, or withdrawal may serve as findings comparable to findings that mark mental disorders in adults."

Comment: One commenter objected to the last sentence of the seventh paragraph of proposed 112.00A (the sixth paragraph in the final listing), which states that "[t]he functional restrictions in paragraph B must be the result of the mental disorder which is manifested by the clinical findings in paragraph A." The commenter believed that this meant that "[i]n order for a child to be found disabled . . . the medically determinable impairment causing one or more of the functional limitations must meet or equal the "A" criteria of a listed impairment." The commenter suggested that we delete the sentence and provide that children can equal a listing if they meet one or more of the paragraph B criteria due to any of the mental impairments included in the DSM–III or DSM–III–R.

Response: We did not adopt the comment, but we have added a new paragraph at the end of 112.00A to emphasize the importance of equivalency determinations. The sentence cited by the commenter occurs only in the context of our discussion of how we will determine whether a child meets a given listing. Our regulations in §§ 404.1526 and 416.926 already provide that a child may equal a listing as the result of any medically determinable impairment or combination of impairments.

The system we adopted in these listing is the same as the system we use in the adult mental listings. Each listing begins with an introductory statement that describes the disorder or disorders addressed by the listing. In most listings, the introductory statement is followed by clinical signs and symptoms (the paragraph A criteria) which, if satisfied, lead to an assessment of the functional limitations in the paragraph B criteria. If a child satisfies all three of these elements in most listings, he or she is found to "meet" the requirements of the

listing. Our only intent in the last sentence of the sixth paragraph of final 112.00A is to establish that, in order to meet the listing, the functional restrictions, in the paragraph B criteria must be the result of the listed mental disorder rather than extraneous causes unrelated to the impairment.

Our policy on equivalency provides that any unlisted impairment or a combination of impairments, no one of which individually meets or equals a listing, may be equivalent to a listing. In §§ 404.1526(a) and 416.926(a) of the regulations, we provide that the test is one of "severity and duration." Hence, under these childhood mental listings, we may find any medically determinable impairment that does not meet a listing to be equivalent to a listed impairment. This would include all of the medically determinable impairments in the DSM–III–R.

In response to this comment and other comments that we describe elsewhere in this preamble, we have added a new paragraph to the end of 112.00A to stress the importance of determining whether a child has an impairment or combination of impairments that is equivalent in severity to a listed impairment whenever we find that the child does not have an impairment that meets a listing. We share the concerns of this commenter and several others that diagnosis of mental disorders in children can be quite difficult, especially in young children. Therefore, we want to be very clear that one should not assume that the failure of a child to present evidence of a particular listed impairment ends the inquiry into whether the child is disabled. This new language is consistent with language we recently added in 110.00C; to stress that children with multiple impairment syndromes often suffer from combinations of impairments and may have impairments that are equivalent to a listing even if they do not meet a listing.

112.00B Need for Medical Evidence

Comment: Two commenters commented on our use of the terms "medical," "sources of medical evidence," "psychiatric signs," and "psychological test results." With regard to the first three terms, the commenters were concerned that the choice of language precluded or limited the type of acceptable evidence from psychologists; one of the commenters thought that the fourth term could not describe "medical" information because it described psychological evidence.

Response: We do not believe that there is any need to revise the language of these listings in the way the commenters suggested since it is consistent with language we use throughout the regulations. However, we have revised the first sentence of 112.00B because we agree that it was unclear.

The terms cited by the commenters are terms of art that are defined elsewhere in the regulations. Sections 404.1513 and 416.913 define the term "acceptable medical sources," and specifically include licensed or certified psychologists. Similarly, §§ 404.1528 and 416.928 state that "medical findings consist of symptoms, signs, and laboratory findings." They further define "signs" as including "psychological abnormalities," and later explain that this includes psychiatric signs. "Laboratory findings" include "psychological phenomena which can be shown by the use of medically acceptable laboratory diagnostic techniques," including "psychological tests." Therefore, our regulations provide that licensed or certified psychologists are sources of medical evidence, including the kinds of psychiatric findings that are a part of their practice, and that medical evidence includes the results of psychological testing.

However, in considering this comment we noted that the first sentence of 112.00B did not state our policy clearly because it seemed to state that psychological and developmental test findings were not "laboratory findings." We have revised the sentence to make it consistent with the remainder of the regulations.

Comment: One commenter thought that the definition of "symptoms" in 112.00B was too narrow. The definition we gave was "complaints presented by the child," and the commenter pointed out that, even though a symptom is experienced by the child, the child may not always "present" the symptom; a parent or other person may note the symptom, rather than the child.

Response: In these regulations, the word "symptom" is a term of art, defined in §§ 404.1528(a) and 416.928(a) as "your own description of your physical or mental impairment." Therefore, our definition of the term in the proposed rules was correct in the context of our regulations. However, this does not mean that we do not consider information from parents, teachers, caretakers, and any other individuals who observe and report what they perceive as the child's experience of a symptom. On the contrary, these final rules make it clear that we consider such observations to be very important evidence. They just do not fall within the regulatory definition of "symptoms."

112.00C Assessment of Severity

Comment: Two commenters suggested that we provide definitions of terms used in these listings. One commenter recommended that we define all of the terms, because clear and concise definitions of the terms would eliminate subjectivity. The other commenter suggested that we provide definitions for the terms "cognitive/communicative" and "personal/behavioral," which we introduced in 112.00C. The commenter was concerned that, without such definition, nonprofessional adjudicators would not apply the terms uniformly. Both commenters asked us to define the term "marked," and one asked us to provide examples to illustrate how we would use the term.

Response: We have not adopted the comments. Most of the terms cited by the first two commenters are standard medical terminology, well-known to all professionals who make use of them. We do not generally provide definitions for any such terminology anywhere in our listings unless we intend to use a term as a term of art.

Furthermore, even though we have not specifically defined all of the terms cited by the commenters, we have provided guidance in the subparagraphs of 112.00C that is tantamount to a definition of some of the terms. For example, with regard to the second commenter's recommendations, 112.00C1b of the final rule provides that:

> Cognitive/communicative function is measured using one of several standardized infant scales. Appropriate tests for measure of such function are discussed in 112.00D * * *.

It also states that:

> For older infants and toddlers, alternative criteria covering disruption in communication as measured by their capacity to use simple verbal and nonverbal structures to communicate basic needs are provided.

Similarly, 112.00C2a provides:

> In the preschool years and beyond, cognitive function can be measured by standardized tests of intelligence although the appropriate instrument may vary with age. A primary criterion for limited cognitive function is * * *.

We believe that it is this kind of guidance that will minimize subjectivity and ensure that our adjudicators apply the rules uniformly.

For the measure of listing-level functional restriction, we provided he same definition for the term "marked" as in the adult mental listings, i.e., more than moderate but less than extreme. We decided not to provide examples of "marked" impairment in the listings because we believe that it is impossible

to devise a single example, or even two or three examples, that would uniformly illustrate the definition of the term. Any example we devised would have to be as clear and unambiguous as we could possibly make it; we believe that an unambiguous example would have to be so obvious that it would not provide useful guidance. We are also concerned about the possibility of misinterpretation. We do not want to create a situation in which some people might assume that our examples were the only examples of the level of marked impairment of functioning and apply the rules too narrowly.

Comment: Several commenters were concerned about the provision in the first paragraph of proposed 112.00C which provided that, when we assess the functional limitations caused by a disorder, we give preference to the results of standardized testing over clinical findings. One commenter thought that the proposed rules placed a much stronger emphasis on objective test scores that the experts originally proposed. Another commenter suggested that we adopt as a model a recent final regulation of the U.S. Department of Education ("Early Intervention Program for Infants and Toddlers With Handicaps," 34 CFR part 303), which requires every evaluation and assessment to be based on informed clinical opinion and also discusses the special importance of clinical opinion when standardized measures are unavailable or inappropriate. The Department of Education regulation was first published at 54 FR 26306, June 22, 1989. All of the commenters were concerned that the emphasis on standardized testing in the proposed rules could imply an intent to downplay the importance of clinical findings or result in inappropriate use or purchase of testing.

Response: We have partially adopted the comments. We believe that the results of a valid, reliable test, as defined in 112.00D, are the best evidence of a child's ability to function and will ensure to the greatest extent possible that we assess functioning accurately, fairly, and uniformly. However, inherent in our definition of what constitutes a valid, reliable test is the understanding that the clinician has considered other medical findings (including clinical signs and the claimant's symptoms, as defined in §§ 404.1528 and 416.928) and any other information that could have a bearing on the assessment of the validity of the results. This would include historical information and information about daily activities, socialization, etc., from both medical and nonmedical sources. Therefore, we did not intend that these rules downplay the importance of clinical evidence; on the contrary, our intent was to build in recognition of the importance of clinical findings in every adjudication.

Nevertheless, we agree with the commenters that the proposed language was not as clear as it could have been. We have, therefore, made changes throughout final 112.00D, the paragraph B criteria of listing 112.02, and in final listing 112.12 (proposed listing 112.10), to clarify our intent and to address the commenters' concerns. In listings 112.02B and 112.12A and B, we have replaced the word "clinical" with the terms "medical" or "other medical" wherever it occurred. We used the word "medical" because it is the terminology we use in §§ 404.1525, 404.1526, 416.925, and 416.926 when we explain that decisions under the listings must be based on "medical findings" consisting of "symptoms, signs and laboratory findings." We provide the same definition of medical findings in §§ 404.1528 and 416.928.

We added explanations to the first paragraph of 112.00D to indicate that, whenever a medical source provides information about functioning, whether it be from medical examinations or standardized testing, we expect that the medical source will have followed standard clinical practice and considered medical history and any relevant information from parents and other individuals. We further provided that adjudicators may request information from nonmedical sources to supplement the record of the child's functioning.

In addition, 112.00B of the former listings contained a clause that was intended to convey our policy on consistency of the findings with the whole record with respect to measures of intellectual functioning. The clause stated that, "any discrepancies between formal test results and the child's customary behavior and daily activities should be duly noted and resolved." In response to the comments, we have restored this provision to the final rules and have placed it in the seventh paragraph of 112.00D to indicate that we have broadened it to include any kind of psychological test.

We have not added specific language to 112.00C to reflect these principles. Instead, we have added a cross-reference to 112.00D in the first paragraph of 112.00C so that it will be understood that the explanations in 112.00D apply to the instructions in 112.00C. We also modified the first paragraph in 112.00C to indicate that in most functional areas either standardized testing or other medical findings may be used to document severity, although valid test results are still preferred when they are available.

Finally, we have reviewed the Department of Education regulations and the attendant discussions in the Federal Register cited by the commenters. We do not believe that our regulations serve the same purpose, and this fact limits comparison with standards used by other agencies. However, we also believe that these revisions and other revisions described in a later response make clear that our policy is consistent with the Department of Education's insofar as it can be compared to the disability programs administered by the Social Security Administration.

Comment: Three commenters noted that there were inconsistencies in the terminology used to describe children from birth to 1 year and 1–3 years in 112.00C, 112.00D and listing 112.10.

Response: We agree. We have therefore standardized the terminology used to describe these age groups in the final regulations. The term "newborn and younger infants" now refers to children from birth to attainment of age 1, while "older infants and toddlers" now refers to children age 1 to attainment of age 3. The term "infants and toddlers" refers to both groups as a whole; that is, from birth to attainment of age 3.

Comment: Two commenters noted that 112.00C provides guidance for assessing severity in five different age groups (birth to attainment of age 1, age 1 to attainment of age 3, age 3 to attainment of age 6, age 6 to attainment of age 12, and age 12 to attainment of age 18) but that the paragraph B criteria of the listings recognize only two categories (age 1 to attainment of age 3 and age 3 to attainment of age 18). One of the commenters pointed out that the paragraph B criteria also do not include newborn and younger infants, up to age 1. Both commenters recommended that we adopt the same age category for the paragraph B criteria as we included in 112.00C.

Response: We have not adopted the comments. We believe, as did the experts that helped us formulate the paragraph B criteria, that it is appropriate to group ages 3 to 18 together under the same functional domains in the B paragraphs because these criteria are relevant to the entire age group. However, we recognize that the impairment manifestations and the methods of evaluating these manifestations vary from different age

levels within the group. This is why we have provided three subdivisions of the age-3-to-18 group in 112.00C2, 3, and 4.

The functional domains provided in listing 112.02B generally are applicable to the age group of birth to attainment of age 1; however, they do not address all of the domains pertinent to this age group, therefore, we provided a new, separate listing 112.12 (112.10 in the proposed listings) that is specifically tailored to the assessment of severity of this group's impairments. We believe this listing will provide a more realistic assessment of very young children and help to ensure uniform adjudications. However, the functional domains in the paragraph B criteria that are applicable to these children are incorporated in final listing 112.12.

Comment: One commenter thought that our statement in the first paragraph of proposed 112.00C1 that, "[i]n infancy, much of what we can discern about mental function comes from observation of the degree of fine and gross motor function," was in error. The commenter pointed out that there are standardized tests to measure cognitive skills and language ability in infants and very small children.

Response: We agree with the commenter. We did not mean to give the impression that there are no tests to measure these abilities in infants and toddlers. We were only indicating in 112.00C1 that, despite the existence of these tests, we would not ordinarily expect to find them in the evidence of record. Hence, our basic thrust in the first paragraph of 112.00C1 was to describe the kind of existing evidence we would expect to find: Assessments of a child's gross and fine motor function. We have, therefore, revised the language of 112.00C1 and reorganized 112.00C to clarify our intent.

Comment: Another commenter asked us to revise the rules to reflect the fact that in some cases abnormalities on screening tests may be so severe that further testing is unnecessary.

Response: We agree with the commenter and have modified the last sentence of the first paragraph of 112.00C1b and the twelfth paragraph in 112.00D of the final rules to reflect the recommendation. The new language indicates that, while screening tests performed during clinical examinations generally do not have high validity and reliability and are not considered appropriate primary evidence for disability determinations, there will be cases in which the results of screening tests show such severe abnormalities that further testing will be unnecessary.

Comment: One commenter stated that the use of age-appropriate social functioning as a severity criterion could be problematic because there is no one standard of social functioning. This could result in wide variations in adjudication.

Response: We recognize that there are a number of tests which measure various aspects of social functioning, and that not all tests yield identical findings. However, we believe tests that satisfy our requirements for validity and reliability generally assess the same or similar behavioral spheres. We also believe that any variations among the tests will not have a substantive effect on determinations under these rules.

Furthermore, in 112.00C we have provided guidance for assessing social functioning in children at four separate age levels. We provided this kind of detail to ensure against the variations in adjudication that the commenter was concerned about.

In considering the comment, however, we noted that proposed 112.00C2 (preschool children) and 112.00C3 (primary school children) did not provide as much detail on assessing social functioning as their counterparts in 112.00C1 (older infants and toddlers) and 112.00C4 (adolescents). We have therefore added language to final 112.00C2b and 112.00C3 to provide similar guidance.

Comment: One commenter expressed concern over our ability to document properly maladaptive or avoidant behaviors and limitations in social function for preschool children, age 3 to attainment of age 6. The commenter stated that most information for this age group will necessarily come from parents, who "at times prove to be either unreliable or poor historians."

Response: A hallmark of these listings is the emphasis on professional evaluations, with standardized testing whenever possible. In any case, standardized testing should be associated with an assessment of the consistency of the findings with the medical and other evidence, especially evidence from parents and other interested adults who have knowledge of the child's day-to-day functioning.

In most psychiatric and psychological evaluations, clinical assessment implies more than the examiner's own observations of the child; it also includes careful probing of the child's history and current functioning outside of the clinical setting. Clinicians are well aware that they have a duty to evaluate the accuracy and consistency of any information received from third parties, or for that matter, from the patient himself or herself, before they use the information in formulating a clinical judgment.

We acknowledge that some preschool-age children will have fewer sources of evidence that school-age children, although this phenomenon is becoming increasingly rare. However, and aside from the fact that we do not agree with the comment that "parents" as a group are any less reliable witnesses of their children's symptoms and behavior than other people who might give evidence, we also do not believe that there will generally be any greater difficulty in evaluating the claims of these children than of older children who are also still primarily in the care of their parents.

Nevertheless, to clarify the intent of these rules, we have modified final 112.00C2b (the second paragraph of 112.00C2 in the proposed rules) to indicate that social function is measured by assessment of a child's relationships with parents, other adults, and peers. This will mirror the discussion already in 112.00C2c (the third paragraph of 112.00C2 in the proposed rules), regarding the assessment of maladaptive or avoidant behaviors. However, we have also provided additional guidance on sources of information about children's functioning to underscore our policy that nonmedical sources of information frequently are very important to a valid assessment of functioning outside the clinical setting both in the present and over time. We have similarly expanded 112.00C2c to include the same sources of information for evidence of personal and behavioral functioning.

Comment: One commenter was concerned about the reference in 112.00C3 to standardized measures of academic achievement. The commenter stated that the instruments used by school districts varied so widely that we should provide more definitive guidance on how to measure this criterion.

Response: We agree with the comment that the reference in proposed 112.00C3 regarding the use of standardized measures of academic achievement requires clarification. Standardized measures of academic achievement are generally designed and used to measure the effects of a specific program of instruction or training. They are not designed to measure function in the domains contained in 112.02B, particularly cognitive function. Poor performance on such measures may or may not be indicative of functional impairment causally related to a medically determinable mental impairment. Therefore, we have deleted the second sentence of proposed 112.00C3, which stated that poor performance on standardized measures

of academic achievement directly correlates with impairment in function. In its place, we now state that "standardized measures of academic achievement may be helpful in assessing the cognitive impairment." The presence of cognitive impairment, if any, can only be determined by the specific facts of each case.

Comment: We received many comments about the proposed statement in the first paragraph of 112.00C4 that, in the cases of adolescents, "if, based on the description of the disorder by the clinician, the adjudicator believes the medical criteria of part B do not apply, the adult listing crite[r]ia will be used." All of the commenters expressed concern that this would require adjudicators to apply the adult paragraph B criteria to children whether or not the children had work histories; many of these commenters recommended that we use this rule only for children who had work histories or histories of work attempts. Other commenters recommended that we require adjudicators to use the childhood paragraph B criteria, even when they used the adult paragraph A criteria.

Several commenters also pointed out that the phrase "the description of the disorder by the clinician" was vague because it did not provide a clear standard by which adjudicators could judge whether to use the adult listings instead of the childhood listings. The commenters reminded us that adolescents are still children, and that the presentation and effects of mental disorders in adolescents are not the same as in adults, even though they may appear similar. Therefore, some commenters urged us to clarify the language to permit use of the adult listings only when a clinician has determined that the symptoms and characteristics of a child's disorder represent early onset of a condition properly diagnosed as an adult disorder. One commenter suggested that we provide that the adjudicator could not turn to the adult listings unless none of the childhood listings could apply; the commenter believed that in this circumstance we should require consideration of the adult listings.

Response: We agree with the commenters that the intent of this language was unclear as proposed, and we have deleted the sentence. Our intent was only to reflect the policies in §§ 404.1525 and 416.925, and the introductions to Parts A and B of the listings, that the adult listings will be used whenever the criteria in the childhood listings do not apply. These are general policies, intended for use with all the listings, not just the mental listings. However, we believe that they will rarely apply to childhood mental disorders because we have provided so much guidance for the evaluation of mental impairments in children, in recognition of the fact that mental disorders in children usually require different considerations than in adults, that most childhood mental disorders will be covered.

Comment: Two commenters pointed to the language in the third paragraph of proposed 112.00C4, which explained that school grades and the need for placement in special education "are relevant factors which must be considered in reaching a decision under paragraph B2d" but "are not conclusive." The commenters thought that this language would be confusing to adjudicators because it appeared inconsistent with statements in proposed 112.00C3 and the fourth paragraph of 112.00D, both of which emphasized the importance of information from school records. One of the commenters was concerned that adjudicators would give little weight to grades or placement in special education unless we provided more detailed instructions. The commenter requested that we clarify how we will assign "weight" to information from school records.

Response: We have not adopted the comments. The language in proposed 112.00C4 (which we have moved to the second paragraph of 112.00C3 in these final rules) states plainly that grades or the fact of placement in special education alone is insufficient to establish that a child has met the paragraph B2d criterion. It explains that this is because the criteria for grading and for special education placement vary too widely among school districts for us to be able to make any reliable generalization. This does not mean that we will not consider such evidence; only that, by itself, the evidence is insufficient to establish conclusively that the child has met one, particular paragraph B criterion.

This is not inconsistent with the two other provisions cited by the commenters. Both sections provide that school records can be a rich source of information about functioning, of test data, and of longitudinal evidence to complete a record. Inasmuch as these passages clearly address a much broader subject than the discussion now in the second paragraph of final 112.00C3, we do not agree that adjudicators will believe them to be in conflict.

We also did not adopt the comment asking us to provide clarification on how an adjudicator should "weigh" evidence from school records. In a sense, the provision in the second paragraph of final 112.00C3 is an instruction on how to assign weight to one kind of school evidence; that is, it provides that evidence of a child's grades or placement in special education cannot alone be given conclusive weight on the issue of whether the child meets the paragraph B2b criterion. Beyond that, we do not believe that it would be appropriate to provide additional guidance on "weighing" this or any other evidence in the context of the listings, just as we do not provide guidance in any listing on how adjudicators should "weigh" credibility or opinion evidence, or any other evidence that requires careful consideration of the individual facts of the case in the context of the entire record.

112.00D Documentation

Comment: One commenter stated that pediatricians are frequently more knowledgeable about children's developmental disorders, such as developmental delay, learning disabilities, and attentional problems, and that they have important expertise which differs from that of many child psychiatrists. The commenter recommended that we include the term "pediatrician" wherever we used the words "psychiatrist" and "psychologist."

Response: We have adopted the comment. The phrase "psychiatrist and psychologist" appears only in 112.00D. We have replaced the phrase with the phrase "psychiatrist, psychologist, or pediatrician" in the fifth paragraph, and "psychologist, psychiatrist, pediatrician, of other physician specialist" in the sixth, eighth, and fifteenth paragraphs. We used the second phrase in the paragraphs that discuss psychological testing because some tests may properly be administered by other kinds of physicians as well.

We did not change other terms in 112.00D, such as "medical sources," "physician," and "treating source," because they are nonspecific and will be understood to include pediatricians.

Comment: One commenter stated that our current regulations recognize only Ph.D. clinical psychologists as acceptable sources of medical evidence and that evidence from school psychologists who do not have doctorates "is not admissible by the SSA." The commenter requested that we revise the regulations to include both

clinical psychologists and school psychologists.

Response: Current §§ 404.1513 and 416.913 provide that we will recognize as acceptable medical sources any licensed or certified psychologists; this includes school psychologists who are licensed or certified. We do not require psychologists who submit evidence to us to have doctorates in clinical psychology. We do have more stringent rules for psychologists who work for us as adjudicators. These rules are set forth in Subpart Q of Part 404 and Subpart J of Part 416 of these regulations.

We would also like to clarify for the commenter that we do not refuse evidence from any source, even if the source is not an "acceptable" medical course under §§ 404.1513 and 416.913 of our regulations. Other provisions in these regulations state that we consider information from other sources. Thus any information may be submitted and will be considered in our assessment even though it is not evidence from an "acceptable" medical source.

Comment: One commenter was concerned that we did not provide a paragraph similar to the second paragraph of 12.00D in the adult mental listings to describe the various medical and nonmedical sources of evidence. The commenter further noted that the paragraph B criteria seemed to "undercut" the value of sources like parents and other concerned adults by requiring documentation in the form of appropriate standardized tests or clinical findings. In addition, the commenter stated that the paragraph B criteria should include a category of evidence from parents and other concerned adults among the acceptable documentation of functional limitation.

Response: We agree that the language we proposed could have been misinterpreted and that it did not include sufficient discussion of important sources of evidence, such as parents. As we explained in an earlier response, we have made changes throughout 112.00D and provided a cross-reference in 112.00C to 112.00D; the changes are intended to address this comment as well as the earlier comment. Furthermore, we have revised the criteria in listings 112.02B and 112.12 to be consistent with the discussions in 112.00D and to replace the word "clinical" with the word "medical" or the phrase "other medical," consistent with our regulations. However, the term "medical" is not meant to imply objective signs alone. It also includes assessment of a child's symptoms and thorough evaluation of all the available evidence.

To assure that the word "medical" is not misunderstood, we have provided new discussions stressing the importance of information from other sources and the role of such evidence both in the medical source's findings and in our development and evaluation of evidence in the case. To clarify how we used the term "medical," we have provided a parenthetical restatement of the regulatory definition of "medical findings" in the first paragraph of 112.00D. We have also provided parenthetical explanations in three of the paragraphs B criteria to serve as reminders of the principles in 112.00D. We believe that these extensive revisions should address the commenter's concerns, while they also clarify our policies.

Comment: Several commenters, again referring to the recent Department of Education regulations, questioned our position that there are standardized instruments for measuring developmental delay in infants and toddlers. These commenters recommended that we place greater emphasis on "informed clinical opinion" when we determine the degree of delay.

Response: Insofar as our rules can be compared to the rules of another agency, we believe that our rules are consistent with the rules promulgated by the Department of Education. However, we have revised the language of the final rules to make absolutely clear that informed clinical judgment is important in all evaluations, including those that ultimately rely on the results of standardized testing. Of course, when standardized test results are not available, other medical findings—which include clinical findings and, generally consideration of information from other sources, such as the claimant's parents, teachers and caregivers—become the sole means of assessing functional impact.

Furthermore, because we believe that our proposed use of the term "clinical" throughout these listings did not convey our intent to include all of the aforementioned important sources of information, we have revised both the preface and final listings 112.02B and 112.12 to remove the term and clarify our intent.

Comment: One commenter asked us to indicate the "weight or value" to be given to tests that rely on self-reports or reports of caretakers, as these are often important sources of valid information.

Response: We believe that we have clarified our intent in the preceding responses. It would obviously be impossible for us to provide absolute rules on the "weight or value" of every test, not only because there are so many different kinds of tests, but also because each child's case will be unique and must be evaluated on its own merits. The foregoing responses essentially explain that the "weight or value" we will give to any test results will depend on numerous factors. Certainly, statements by the claimant and others who know the claimant are very important factors in this consideration. For this reason, we provided discussions in the opening paragraphs of proposed 112.00D to describe various possible sources of information about the claimant and to underscore the importance of obtaining information from them. We have now revised 112.00C and 112.00D to emphasize this policy in the final rules. We also emphasize the importance of this kind of evidence in establishing a longitudinal record. In addition, we have provided that any test results should be correlated with the clinical findings and other evidence.

Comment: Two commenters expressed concern about the language in the second paragraph of 112.00D, which provides that we may hold the cases of some infants until they attain age 3 months in order to obtain adequate observations of behavior or emotional affect. The commenters suggested that this section should clearly state that development of medical evidence continue while a case is being held, and that any delay in securing evidence not adversely affect a child's date of eligibility for SSI payments. In addition, they recommended that we provide more definitive guidelines for the length of time that a premature infant's case can be held.

Response: We agree with the commenters that the paragraph was not clear and have, therefore, revised it to make it clearer. Our intent in this paragraph is not to delay the development of a case or to delay any child's eligibility for benefits. Rather, we want to prevent an inappropriate denial when there is evidence that a child has a developmental impairment but, because of the child's young age, the severity of his or her impairment cannot be determined.

We did not adopt the suggestion to provide "definitive" guidelines for the length of time a premature infant's case may be held because each infant's case will be different. Prematurity in and of itself does not establish impairment severity or guarantee that an infant will meet the 12-month duration requirement, and in the first months of a premature infant's life medical attention is often focused primarily on ensuring the

infant's survivial, not on measuring his or her abilities. Therefore, the amount of time a premature infant's case can be held will necessarily depend on a careful judgment based on the specific facts of the case. To clarify this principle, we have added language to the paragraph to indicate that the decision to extend the 3-month period will depend on the degree of prematurity and the adequacy of documentation of the child's development and emotional status.

We did not adopt the suggestion to add a discussion about the date on which eligibility for SSI should be established. We believe that our existing policies on establishing dates of onset and eligibility for SSI (ordinarily, the date of filing of the application) are adequate to address this issue and are inappropriate in the context of specific listings because they are not unique to childhood mental disorders.

Comment: A commenter questioned the language in the fifth paragraph of 112.00D, which provides that "[i]n some cases . . . it may be necessary" to obtain evidence from a consulting psychiatrist or psychologist when a claimant's treating source lacks expertise in dealing with mental disorders in children. The commenter stated that we should not make the rule optional, but require development with consulting specialists in every case in which the claimant's treating source is not an expert in mental disorders.

Response: We did not adopt the comment. Our policy is that when a treating source provides us with sufficient evidence for us to make our decision (which also means that we have no good reason to question the evidence), we will not obtain a consultative examination solely to confirm or refute the treating source's evidence. If a treating source cannot supply the kinds of information we need to evaluate a case properly under these listings, we will of course develop the evidence further.

We, therefore, intentionally provided in the fifth paragraph of 112.00D for the situation in which a claimant's treating source, though not an expert in the evaluation of mental disorders, nevertheless provides sufficient clinical and laboratory findings (including psychological testing, as necessary), opinions and other relevant evidence for us to make a decision under these rules. We think that such cases are likely to be rare, both because many children with significant mental disorders will have treating sources who are experts in the treatment of mental disorders and because treating sources who are not experts in mental disorders will not ordinarily be able to supply information that is complete enough for us to make a final determination or decision; however, we want to provide for the possibility.

Comment: Several commenters stated that more discussion was needed on the availability, applicability, and usefulness of standardized testing in connection with assessing the functional impact of mental disorders occurring during childhood. Specifically, they asked us to include a list of the tests we will use, or examples of some of the tests we will use, for assessing these areas. Two commenters recommended that we include a list of tests developed by the experts who assisted in the development of the proposed rules.

Response: We have not adopted the comments. We agree with the commenters that these listings do not identify all tests that may be useful in evaluating the functional impact of mental disorders. However, we do not believe that the regulations are the appropriate forum for providing this guidance.

Because of the large number of tests available, it would be practically impossible for us to publish and maintain a list of all available acceptable tests. Moreover, any list that included only examples of tests, such as the list prepared by the experts, could give the misleading impression that we have given our exclusive support to certain instruments. Furthermore, we would expect most professionals to follow standard practices in choosing the tools for evaluation, and we are confident that the mental health professionals we employ are aware of the available instruments.

For all these reasons, we decided that instead of naming additional specific tests, we would provide in the seventh paragraph of 112.00D a detailed description of our criteria for judging whether a test is "good," based upon its validity, reliability, and whether it is based on appropriate normative data. Any test that meets these standards constitutes acceptable documentation for the purposes of these listings.

When we promulgate any listing revisions, we routinely consider the need to update our supplemental training materials and other guidelines to ensure that our adjudicators have an appropriate and uniform understanding of the new rules and how to apply them. We believe that these are the appropriate vehicles for listing any additional examples of acceptable tests.

Comment: One commenter stated that our proposal to base listing 112.05 on IQ scores obtained from the Wechsler Intelligence Scale for Children-Revised (WISC-R), and our failure to mention other well-recognized tests included in the DSM-III-R would place the burden of establishing the validity of these other tests on the claimant.

Response: The proposed language was intended only to codify our existing policy. The IQ scores in both the former listing 112.05 and these final listings were derived from the WISC-R, which is one of the best known and most widely used scales. It was not our intent to place the burden of establishing the validity of other test results on the claimant; as we have always done, we will recognize the validity of other tests that meet our standards for validity and reliability.

For this reason, we included the discussion in the eighth paragraph of proposed 112.00D, now the ninth paragraph in the final rules, which recognizes the validity of other tests, but explains that identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual function because they may be based on a different mean and standard deviation. We, therefore, caution our adjudicators that it may be necessary to find a common denominator—percentile rank in the general population—in order to compare IQ scores from other valid tests with the standard in the listing. However, in response to the comment, we have expanded the ninth paragraph of final 112.00D to explain how we chose the IQ scores we use in 112.05 and to provide additional information about the mean and standard deviation of the Wechsler scales for purposes of comparison. In view of these revisions, we have also deleted the similar language we proposed in the opening paragraph of listing 112.05.

Comment: Another commenter stated that the language in the eighth paragraph of proposed 112.00D was confusing, although the commenter did not specify what about the language was confusing. The commenter suggested that it either be deleted or that we provide conversion charts to show the corresponding percentile ranks in the general population of IQs obtained on some of the more common tests that are not based on the same mean and standard deviation as the Wechsler scales.

Response: The language in the eighth paragraph of proposed 112.00D (the ninth paragraph in the final rule) reflected our longstanding, uniform policy for use of non-Wechsler series intelligence tests, which is currently found in Part A, in the seventh paragraph of 12.00D and listing 12.05.

and in Social Security Ruling 82–54. However, as we explain above, we have added more detail about our policy in the paragraph to clarify our policy for this commenter.

We did not adopt the recommendation to publish conversion charts as a part of these rules. The paragraph does not announce a change in policy, nor have we experienced any difficulties in adjudicating cases using these rules under either the childhood or adult listings. The conversions are not a matter of substantive policy but of fact: Any properly trained psychologist can determine the corresponding percentile rank to a given IQ score in a given test. Moreover, we do not include such factual medical detail in any of our other listings.

In addition, there are so many possible alternative tests that any chart that attempted to provide the detail requested by the commenter would be cumbersome and of necessity incomplete. In the unlikely event that there are widespread difficulties converting test results in the future, we will provide guidance to our adjudicators.

Comment: A commenter suggested that we either incorporate our internal operating instructions on evaluating psychological testing into these listings or obsolete them.

Response: Our internal operating instructions, e.g., the "Program Operations Manual System," have their basis in the Act and our regulations. The purpose of our internal operating instructions is to provide guidance to our adjudicators for a uniform understanding and use of the policies contained in the Act and regulations. It would be inappropriate for us to include all of these instructions in the regulations or to rescind those that we have not included.

However, we have reviewed our internal operating procedures again, and we believe that it is appropriate to add a new tenth paragraph to 112.00D to emphasize the importance of considering the recency of IQ tests and the consistency of the results of the tests with the child's behavior when evaluating claims under listing 112.05. The new language provides that the currency of IQ test results depends both on the child's age at the time of testing and the actual IQ scores, and includes our longstanding guidelines for making this assessment.

Comment: One commenter stated that the twelfth paragraph of proposed 112.00D (now the 13th paragraph in the final rule) conflicted with 112.00C1. The proposed paragraph used the Gesell Developmental Screening Test as an example, whereas the second sentence of the second paragraph of proposed 112.00C1 cautioned against the use of developmental screening devices when assessing cognitive/communicative function in children aged 1 to 3.

Response: We have adopted the comment, even though there was no conflict between the two sections. Standardized tests are more reliable measures of function than are gross screening devices and, in spite of its name, the Gesell Developmental Screening Test is a standardized test that meets the salient characteristics of a "good" test as explained in the seventh paragraph of 112.00D. However, since this test is no longer in widespread use, we have deleted it from the examples in the 13th paragraph of final 112.00D.

Comment: Several commenters addressed the statement in the 15th paragraph of proposed 112.00D (now the 16th paragraph of final 112.00D), that any required psychological tests be administered in the child's principal language. They expressed concern that this may not be possible in all situations. Two of the commenters also pointed out that there were other related situations that these provisions could include. For example, one commenter suggested that the situation in which a bilingual child's principal language was not English but the child could be tested in English if a test in the principal language was not available. The commenter proposed that we add language that would permit alternative testing in appropriate circumstances, provided that the child would not be otherwise disadvantaged.

Another commenter asked us to provide information about acceptable workups for non-English-speaking claimants "since existing standardized tests would generally be precluded."

Response: We have adopted most of the comments by clarifying the language of the 16th paragraph of final 112.00D. We did not intend to state or imply that a determination based on the listings could not be made without testing in a child's principal language. We also agree that there will be situations in which we will not be able to test in the child's principal language but could appropriately test in English (or even another language) without disadvantaging the child. To clarify our intent, we have added language similar to that in the fifteenth paragraph of final 112.00D to indicate when testing in the child's principal language is unavailable, we will use appropriate medical, historical, social, and other information when we make our determination. The rule will apply whether or not the child can be tested; however, it should be understood that this information could, in the proper circumstances, include testing that is not in the child's principal language.

We do not agree completely with the generalization about the availability of standardized tests in other languages. There are some languages, such as Spanish, in which such tests are available. We have, however, provided additional guidance in the 16th paragraph of final 112.00D to explain that the best indicators of severity in children from different cultures are often adaptive functioning, activities of daily living, and social functioning, based on reports from treating sources, parents, or others who are familiar with the child.

112.00E Effect of Hospitalization or Residential Care

Comment: Two commenters, who noted that these listings did not include paragraph C criteria comparable to 12.03C of the adult listings, suggested that we provide more detailed guidance in 112.00E for the evaluation of children who may not be able to function outside of structured settings or highly supportive living arrangements.

Response: We agree with the commenters that highly structured or supportive living arrangements may minimize the overt indications of mental disorders. Thus, we have added language to the first paragraph of 112.00E to explain that, when a child is in a structured setting, evaluation of mental disorders must include an assessment of the degree to which the child can function independently, appropriately, and effectively on a sustained basis outside the structured setting.

112.00F Effects of Medication

Comment: One commenter stated that 112.00F should require that attention be paid to the stabilizing effect of medication. The commenter further stated that this should include the likelihood of the individual continuing to take the medication and whether the individual would be disabled if he or she stopped taking the medication.

Response: We did not adopt the comment. Section 112.00F already emphasizes the need to address the stabilizing effects of medication. It points out that, although medication may ameliorate overt symptomatology, the child may nevertheless be functionally impaired and that, furthermore, side effects of the medication may themselves affect the child's ability to function. We do not agree that it is necessary to address the

likelihood that a child will fail to take his or her medication or the possible consequences of such failure in these listings. We have separate policies on failure to follow prescribed treatment, in which we make special provision for children and for all individuals who have mental disorders.

112.02 Organic Mental Disorders

Comment: One commenter suggested that we define the word "persistence" in listing 112.02A.

Response: We did not adopt the comment. The term has the same meaning as in common parlance and does not have any special meaning in these rules. It merely establishes a criterion that the organic mental disorders in the listing must be chronic, rather than acute. Therefore, we believe that it need not be defined.

Comment: One commenter suggested that we combine proposed listings 112.02, 112.09, and 112.10 into a listing labeled "developmental and emotional disorders of childhood." The commenter stated that there was no need to distinguish organicity, autism, and environment as separate etiological entities, that there was overlapping of the listings, and that a combined listing would "then handle learning disabilities and behavior disorders appropriately." The commenter also recommended that the new listing recognize three age groups instead of the two age groups we proposed for the paragraph B criteria.

Response: We did not adopt the comments. While it is certainly true that organic mental disorders, developmental disorders, and developmental and emotional disorders of infancy, as described in the DSM–III–R, cannot always be clearly distinguished, we have nevertheless tried to maintain the distinctions in the DSM–III–R as far as possible in order to conform our rules to current diagnostic criteria and nomenclature. Furthermore, the listings, like the DSM–III–R, are primarily descriptive, largely reflect signs and symptomatology, and do not espouse any particular theories of etiology.

As we explained in an earlier response, we do not believe that it is necessary to have more than two age categories for assessing functional impairment under the paragraph B criteria. The critical areas of function for evaluating children aged 3 to 18 are the same, although the manifestations will vary at different ages; this is why we provided guidance for evaluating three age groups within the age-3-to-18 category in 112.00C.

Comment: Many commenters questioned why certain listed impairments required a greater number of paragraph B criteria than other listings. They pointed out that the paragraph B criteria are the functional measures of listing-level severity; therefore, it should follow that all listings should be met by satisfying the same number of paragraph B criteria.

Response: We agree with the commenters, and have therefore revised all of the listings that have paragraph B criteria. For reasons we explain in detail in the "Explanation of Revisions" section of this preamble, we now require that an older infant or toddler, age 1 to attainment of age 3, must demonstrate functional deficits or restrictions to the degree specified in one of the paragraph 112.02B1 criteria, and that a child, age 3 to attainment of age 18, must demonstrate functional deficits or restrictions to the degree specified in two of the paragraph 112.02B2 criteria.

Comment: A commenter expressed concern about how we will determine whether a child has achieved only one-half of the expected milestones in listing 112.02B and other listings. The commenter asserted that the State agencies have denied claims in which children have demonstrated milestone achievement slightly more than one-half for their age in one area of development even though they met the criteria for milestone achievement in all other areas. The commenter believed that this application of the rule was too narrow.

Response: As a result of this comment and other technical reasons we have explained in the "Explanation of Revisions" section of this preamble, we have revised all of the rules that referred to "a pattern" of milestones, or achievement of "50 percent" of anticipated milestones, or other similar language to explicitly state the number of functional domains in which the child must demonstrate deficiency. We have also revised the language of these rules so that it is more straightforward and less open to interpretation. The criteria now all use uniform language which refers to achievement of milestones generally acquired by children no more than one-half or two-thirds (as appropriate to the specific rule) of the child's chronological age.

112.03 Schizophrenic, Delusional (Paranoid), Schizoaffective, and Other Psychotic Disorders

Comment: One commenter stated that the proposed 6-month standard for the persistence of symptoms in 112.03A seemed unnecessarily long if the point of the standard was to make sure that the symptomatology would not be temporary. The commenter stated that the symptoms described in the listing would be "very uncommon" in children, and thought that a 3-month standard would be enough to establish that the problem was severe. The commenter also stated that exceptions, such as drug-related symptoms, should never last 3 months.

Response: We did not adopt the comment. As in the adult mental listings, the intent of the paragraph A criteria is to describe certain mental syndromes or clusters of syndromes, without any inferences as to severity. Although we have not included every criterion that is in the DSM–III–R, we have based nearly all of the paragraph A criteria on the DSM–III–R, descriptions of syndromes or categories of syndromes.

Listing 112.03A uses the DSM–III–R criterion for chronicity of psychotic symptoms—6 months—applicable both to children and adults. We want to stress, however, that this does not imply, per se, any judgments about the severity of the impairments of children who do not satisfy this paragraph A criterion, nor does it mean that such children cannot be disabled. When a child does not satisfy the specific paragraph A criteria of this, or any other listing, this means only that the child can not meet a listed impairment. The child may still be found disabled under our current rules of medical equivalency or under the rules we are developing to implement the Supreme Court's February 20, 1990, decision in *Sullivan* v. *Zebley et al.* The determination will always depend on the facts of each case.

The comment about drug-related symptoms was unclear to us. Certainly, there are acute symptoms of drug intoxication that the temporary and that may not recur. However, we do not agree with the blanket statement of the commenter that drug-related symptomatology should "never" last 3 months. For this reason, and in response to numerous comments we summarize below, we have added a separate listing 112.09 to address the special problems of evaluating psychoactive substance dependence disorders.

112.04 Mood Disorders

Comment: One commenter thought that the word "currently" in the phrase "currently characterized" in 112.04A3 could imply that symptoms of bipolar disorder must be currently active.

Response: We agree with the commenter that the word "currently" could be confusing. We have, therefore, revised the language in parentheses to more closely follow the language of the DSM–III–R. The statement in parentheses will not read: "* * * (and currently or most recently characterized

by the full or partial symptomatic picture of either or both syndromes)." The changes address two problems. First, in response to the comment, the new language clarifies that a child need not be currently symptomatic in order to meet the paragraph A criteria. Second, it clarifies that the current or most recent episode need not have been manifested by the full symptomatic picture of manic or depressive syndrome, as long as there is a history of the full symptomatic pictures of both syndromes sometime in the past.

112.05 Mental Retardation

Comment: Several commenters noted that we did not include Down syndrome in the proposed listings. Two of the commenters were aware that we had proposed a separate listing for Down syndrome (see 52 FR 37161, October 5, 1987), to be added to 110.00, Multiple Body Systems, but noted that we would not have a listing for the impairment until the new listing was published as a final rule. One group submitted a copy of the comments they made on the NPRM that included the Down syndrome listing.

Response: We now have a separate listing for evaluating Down syndrome; see listing 110.06. We have not responded here to the duplicate comments on the NPRM for Down syndrome since we responded to the comments in the preamble to those final rules.

Comment: One commenter suggested that we define the phrase "developmental period" in the first sentence of listing 112.05. The commenter noted that the corresponding adult listing, 12.05, defines the term as the period prior to age 22.

Response: We did not define the term in 112.05 because in our judgment it is not necessary to provide an age limit in the context of the childhood listings. Sections 404.1525 and 416.925 of our regulations state that part B of the Listing of Impairments applies only to the evaluation of impairments of persons under age 18. Therefore, we have deleted the text in question from the opening of listing 112.05 because it is unnecessary; cases evaluated under 112.05 represent impairments that began before the end of the developmental period.

Comment: One commenter recommended that the IQ range in proposed 112.05C and 112.05D be "60 to 70" instead of "60 to 69" because the DSM–III–R defines mental retardation as involving an IQ of 70 or less.

Response: We concur with the commenter's recommendation and have changed the IQ ranges in final listings 112.05D (proposed listing 112.05C) and 112.05E (proposed listing 112.05D) to read "60 to 70." We have also changed the upper IQ range from 69 to 70 in adult listings 11.07A, 12.00D, and 12.05C and D and childhood listings 109.02B1, 111.02B1, 111.07B1 and 111.08B2.

Comments: Many commenters were concerned that listing 112.05 relied too heavily on IQ scores and failed to take into account all of the possible deficits in adaptive behavior, e.g., meeting standards of maturation, learning, personal independence, and social responsibility that are expected for a child's age level and cultural group. These commenters recommended that we substitute the phrase "marked deficits in adaptive behavior" for the phrase "marked impairment in personal/behavioral function" in section D2 of proposed listing 112.05. One commenter suggested that both sections A and D of proposed listing 112.05 should contain the more flexible language of the DSM–III–R regarding adaptive behavior, as opposed to the more rigid "developmental" limitations set forth in the proposed listings.

Response: We concur with the commenters that deficits in adaptive behavior can serve as a useful alternative to IQ scores. Therefore, as we stated previously in the section of the preamble explaining these final rules, we have added two new paragraph to listing 112.05, paragraphs B and F, which use deficits in adaptive behavior as an alternative to IQ scores, and have revised paragraph A to clarify its use of deficits in adaptive behavior. We have also revised paragraph E, which was proposed as paragraph D, to expand our use of deficits in adaptive behavior in conjunction with IQ scores in the 60 to 70 range.

Comments: One commenter noted that in the NPRM for the listings that included Down syndrome and other similar syndromes we have proposed a fourth criterion for mental retardation to be included in proposed listing 110.06, but that we had not proposed the same rule in the childhood mental listings. The commenter supported the additional rule, which was an alternative to the criteria in former listing 112.05C. The rule provided that a child would meet the listing if he or she had achieved only those developmental milestones generally acquired by children no more than two-thirds of the child's chronological age, and also had a physical or other mental impairment imposing additional and significant restrictions of function or developmental progression. The commenter urged that we make the childhood mental listings consistent with the listings under 110.00.

Response: We have adopted the comment. We have added the rule as 112.05F. We describe the new listing in the summary at the beginning of this preamble. We have also modified final listing 112.05E to include the two-thirds-milestone achievement criterion.

112.07 Somatoform, Eating, and Tic Disorders

Commenter: Two commenters thought that we had not included a listing for eating disorders.

Response: We included eating disorders in 112.07A1 of the proposed listings. We have changed the title of listing 112.07 to "Somatoform, Eating, and Tic Disorders" and added a reference to eating disorders in the capsule definition so that our intent will be clear. In addition, as part of our review of the listings to conform them to the terminology of the DSM–III–R, we have completely revised the language of 112.07A1. We believe that the revision more clearly indicates that this set of A criteria describes eating disorders.

Comment: One commenter thought that Tourette's disorder would not be covered by these listings. Another commenter asked us to provide guidance on which listing to use when evaluating the disorder.

Response: Tourette's Disorder is defined in the DSM–III–R as a tic disorder. We provided criteria in 112.07A2 which can be used for evaluating Tourette's Disorder and other tic disorders. As explained in the previous response, we have revised the title of listing 112.07 to "Somatoform, Eating, and Tic Disorders." We have also added a reference to tic disorders in the capsule definition. These revisions should clarify that Tourette's Disorder and other tic disorders are to be evaluated under this listing.

112.08 Personality Disorders

Comment: Many commenters were concerned about our proposal to include a listing for personality disorders in children that merely referred to the corresponding adult listing, 12.08. One of the most frequent comments was that a reference to the adult criteria would omit psychopathology and certain recognized disorders that are specific to children. In support of their assertion, many of the commenters directed our attention to a statement in the introduction to the chapter on personality disorders in the DSM–III–R. The statement explains that certain disorders of childhood—specifically, conduct disorder, avoidant disorder of childhood or adolescence, and identity disorder—are related to corresponding

diagnostic categories in the chapter on personality disorders. The commenters recommended that we include these disorders and all of their associated diagnostic criteria under listing 112.08. In the alternative, several commenters suggested that we include the phrase "disruptive behavior" in the listing to convey the idea that a full-blown personality disorder is not required for the listing.

Nearly every commenter also questioned our proposal to use the adult paragraph B criteria to evaluate these impairments. The commenters pointed out that, inasmuch as two of the adult criteria are work-related, proposed listing 112.08 would be based on a much stricter standard than the other childhood listings and that it would be unlikely that many children would be able to satisfy the criteria.

Response: As we have stated in the summary section of this preamble, we have adopted the comments to include a specific listing for personality disorders in children, instead of a reference listing. We agree with the commenters that it is inappropriate to relate the functional criteria of the listing to the adult paragraph B criteria, which we acknowledge most children will not be able to satisfy.

We did not, however, adopt the comments that asked us to include conduct, avoidant, and identity disorders as listed impairments under 112.08. The listings are examples of some common impairments that we use to find a child disabled. Although the childhood impairments in the DSM–III–R called "conduct disorder" and "identity disorder" could cause significant functional limitations in individual cases, we did not include them as separate listed impairments because we believe that they generally are not comparable in severity to other listed impairments. In fact, the passage in the DSM–III–C cited by the commenters states that conduct disorder in childhood or adolescence corresponds to the impairment called "antisocial personality disorder" in adults, and we do not list antisocial personality disorder in adult listing 12.08 either. Conduct disorder and antisocial disorder, unlike the other disorders, primarily represent conflicts between the individual and society. Although not listed as separate impairments, conduct disorder and identity disorder would not be excluded from consideration as disabling impairments.

Therefore, we have provided that a child must have a "full-blown" personality disorder in order to meet this listing. This does not mean that we will approach the evaluation of other related impairments with any preconceived notions about their severity in individual cases; only that we believe that these kinds of childhood mental disorders should not be listed impairments. As always, the decision whether any impairment meets or equals a listed impairment will depend on the individual facts of each case.

We did not include avoidant disorder of childhood or adolescence under listing 112.08 only because we had already included it under listing 112.06. Criterion 112.06A2 is intended to capture any disorders that are characterized by avoidance behavior.

For a similar reason, we also did not adopt the comment to include the phrase "disruptive behavior" as a paragraph A criterion in listing 112.08. The reason we did not is that we had already built it into our paragraph B criteria. Paragraph B2c(2) of listing 112.02—that is, the second paragraph in the third B criterion for children age 3 to attainment of age 18—describes "persistent maladaptive behaviors destructive to self, others, animals, or property, requiring protective intervention." As one of the commenters noted in arguing for the use of the childhood B criteria under listing 112.08, these criteria "refer to the very behaviors that are manifest in these disorders."

112.09 Psychoactive Substance Dependence Disorders

Comment: Many commenters asked us to add to the final listings a category of impairment for substance addiction disorders, as originally recommended by the experts. Several of the commenters stated that the listing should be a listing for substance abuse.

Response: We have adopted the majority of the comments and added a listing for substance addiction disorders, now called "psychoactive substance dependence disorders" in the DSM–III–R. We describe the new listing, which we have designated 112.09 to maintain correspondence with the numbering system in the adult listings, in the summary of the listings at the beginning of this preamble.

We have not adopted the comments that recommended that we include psychoactive substance abuse disorders among the listed impairments in listing 112.09. There is too much variability in the manifestations and severity of substance abuse disorders to permit a meaningful description in the listings. Children who have psychoactive substance abuse disorders as their primary mental impairment should be evaluated under this listing using our rules of medical equivalency.

Comment: Several of the commenters who asked us to include a listing for psychoactive substance dependence mentioned that they thought that having such a listing would be valuable because it could be applied to babies who were born with the conditions known as "fetal alcohol syndrome," "fetal cocaine syndrome," or other similar psychoactive substance syndromes.

Response: We consider fetal alcohol syndrome, fetal cocaine syndrome, and other similar syndromes to be multiple body system impairments because they typically present themselves as a constellation of impairments affecting more than one body system and involving more than substance dependence alone. We therefore have promulgated a separate listing 110.07, which includes these disorders. The listing recognizes the profound effect on development the combined impairments associated with these disorders can have.

112.10 Autistic Disorder and Other Pervasive Developmental Disorders

Comment: One commenter stated that proposed listing 112.09 (final listing 112.10), "Autism and Other Pervasive Developmental Disorders," omitted many of the criteria in the DSM–III–R for determining the existence of these disorders. The commenter was concerned that the proposed criteria could cause us to overlook many children who had the disorders.

Response: We have adopted the comment. The proposed criteria were based on the DSM–III, which did not include as much detail as the DSM–III–R. We have revised final listing 112.10 to reflect the more recent criteria.

112.11 Attention Deficit Hyperactivity Disorder

Comment: One of the most frequent comments was that we should have included a separate listing for Attention Deficit Hyperactivity Disorder (ADHD), a category that was recommended by the experts. Most commenters stressed that ADHD is a common impairment in children, that it is well-recognized and clearly defined, and that it is not appropriately captured by any of the listings we proposed. Hence, they believed that ADHD would be best evaluated under its own, separate listing. Three commenters stated their opinion that ADHD will rarely be disabling; however, two of these commenters still thought that a separate listing was necessary because the remaining listings were inadequate to

evaluate the conditions of children who have the impairment.

Many commenters expressed concern that if we did not include a separate listing for ADHD we would never find children with this impairment disabled. One commenter, who is the parent of a child with ADHD, was concerned that we had changed our rules so that children with ADHD could not qualify for benefits; many commenters, echoing this commenter's belief, stated that we had violated the law by eliminating from the listings a medically determinable impairment known to the medical community, and that we had "decreed that no matter how disabled a child with one of the excluded impairments is, his or her eligibility for benefits cannot be established."

Another commenter recommended that any listing for ADHD should not include a paragraph B functional requirement. Finally, one commenter recommended that we include the two other disruptive behavior disorders described in the DSM–III–R, conduct disorder and oppositional defiant disorder, in the listing that included ADHD.

Response: After carefully considering these comments, we agree with the majority of the commenters that we should include a listing for ADHD. We describe the listing in the summary at the beginning of this preamble. However, we want to emphasize that the fact that we do not list a particular disorder does not mean that we will not consider an unlisted disorder or that we would not find a child disabled by an unlisted disorder.

We did not adopt the recommendation to omit the paragraph B requirement from this listing. Children with ADHD exhibit a wide spectrum of impairment, ranging from slight to disabling. Therefore, it is imperative that any listing for ADHD include specific guidance for assessing the severity of the disorder in addition to criteria which establish its existence. We believe that the paragraph B criteria of listing 112.02, applicable in most of the other listings, appropriately describe the kinds of functional impairment associated with ADHD, and have therefore decided to include them in this listing as well.

We also did not adopt the recommendation to include the other disorders described in the DSM–III–R under the heading "Disruptive Behavior Disorders." We have explained our reasons for not including conduct disorder in the listings in our responses to the comments asking that we include it under listing 112.08. For the same reasons, we decided not to include "oppositional defiant disorder," the only other disorder named in this section of the DSM–III–R. Children who have either of these impairments may be evaluated under listing 112.08 or listing 112.11, depending upon the particular facts of their cases, using our medical equivalency rules.

112.12 Developmental and Emotional Disorders of Newborn and Younger Infants (Birth to attainment of age 1)

Comment: Many commenters commented favorably on our proposal to add a listing (proposed listing 112.10, final listing 112.12) specifically for the evaluation of newborn and younger infants, from birth to attainment of age 1. However, they noted that the problems of diagnosing mental impairments can extend to older infants and toddlers, age 1 to attainment of age 3. They urged us to extend the listing to include older infants and toddlers.

Response: We have not adopted the comments, but we have added language to 112.00A and 112.00C to address the commenters' concerns.

Although we agree with the commenters that diagnosis of older infants and toddlers can be just as difficult as in newborn and younger infants, we believe that the problem is not as pervasive in the older group as it is in the younger group. Furthermore, the infant-specific criteria for assessing severity in final listing 112.12 become progressively less appropriate as infants become older. We have, therefore, decided to leave listing 112.12 as we proposed it; that is, as a listing designed specifically for the special problems associated with the evaluation of children from birth through attainment of age 1.

This is not to say that children who are older than 1 cannot be found to have an impairment which is equal to the severity of listing 112.12. As we emphasize throughout these responses, any child who does not have a listed impairment can still be found disabled if he or she has an impairment or combination of impairments that is equivalent to any listed impairment. Children older than 1 whose impairment manifestations are identical or sufficiently similar to the requirements of 112.12 could, in certain situations, be evaluated using the new listing.

In response to this and other comments we have already described, we have added language to 112.00A and 112.00C to stress the importance of deciding whether a child has an equivalent impairment or combination of impairments. In direct response to this comment, we have also added statements in the last paragraph of 112.00A and the second paragraph of 112.00C to indicate that children aged 1 to attainment of age 3 may exhibit similar problems of insufficient developmental differentiation to newborn and younger infants and that it is, therefore, vital to assess equivalency in such cases.

Comment: Several commenters offered suggestions for provisions that permitted presumptions of disability in the cases of the very youngest infants (from birth through the first weeks or months of life). Two of these commenters prefaced their suggestions with remarks about the proposed 50 percent developmental delay rules for newborn and younger infants in paragraphs A and B of proposed listing 112.10. One of these commenters was concerned because he believed that validated instruments for such young children are lacking. This commenter was also concerned that in some impairments, such as Down syndrome, developmental delays are not always immediately apparent. The commenter thought that we might deny such children at or near birth, even when there was a high probability that we would eventually find them disabled. The other commenter stated that under current regulations a finding of disability in children with genetic or congenital impairments cannot be made until the disability has manifested itself in 50 percent developmental delay.

With regard to the suggested provisions for presumption of disability, several commenters provided examples of some of the hereditary and congenital conditions they would include, based upon the likelihood that children with these impairments would eventually be found disabled when they were older. One of these commenters also suggested that this would be an equitable rule because most of the children who have one of these conditions would eventually be found disabled and eligible for benefits when they were older. Therefore, such a rule, in the view of the commenters, would only serve to provide such children with their rightful benefits in a more timely fashion.

Response: We disagree with the comment about the existence of valid tests for children from birth through attainment of age 1. As we state in the 13th paragraph of 112.00D, there are validated instruments appropriate to newborn and younger infants, such as the Bayley Scales of Infant Development and the Cattell Infant Intelligence Scale. Furthermore, all of the listings provide alternative criteria to testing; the criteria in final listing 112.12A and B (proposed listing 112.10A and B) are only two

criteria of five, which can be used to meet the listing.

Nevertheless, we share these commenters' concerns that some impairments can be especially difficult to evaluate in the very youngest infants. One of our major goals in devising these listings and the new rules in 110.00 and listings 110.06 and 110.07 was to address the problems of evaluating both mental and physical impairments in newborn and younger infants. Even though it is not true, as two commenters suggested, that we had no provision in our policy for finding disability in infants who did not demonstrate 50 percent developmental delay, we have been keenly aware of the difficulty of performing these evaluations. Final listing 112.12 is an innovation in our childhood listings: It is a rule that provides criteria specifically for children in their first 12 months. Similarly, new listing 110.07 recognizes the special problems associated with the assessment of severity in the children who have confirmed hereditary, congenital, or acquired conditions that usually affect two or more body systems. In addition, we have established certain listings under which a child can be found disabled by virtue of a medically documented diagnosis and its well-established medical and functional implications. New listing 110.06, which covers Down syndrome (except for the mosaic form), is one of these. This listing provides for a finding of disability based on Down syndrome established by clinical and laboratory findings.

In our view, new listing 112.12 and the new listings in 110.00 go a long way toward resolving the problems raised by the commenters. These new rules provide considerably more detail for evaluating impairments in newborn and younger infants than we have previously provided to our adjudicators; they provide for more timely assessments of claims; and they provide alternative criteria to the rule for 50 percent developmental delay. In addition, we will provide further guidance in the new regulations we are now preparing in response to the Supreme Court's decision in *Zebley*.

Comment: One commenter thought that the rule in proposed listing 112.10 for a developmental delay of 50 percent was inappropriately low because it did not equate with the requirement in proposed listings 112.05C or D, which recognized disability in older children who had IQs as high as 69. The commenter suggested that we increase the milestone rule from 50 percent or less to 69 percent or less.

Response: We have not adopted the specific suggestion, but have added a new rule that we believe responds to the comment.

Our intent in proposed listing 112.10, now final listing 112.12, was to create a listing for newborn and younger infants that would equate with the severity threshold in listings 112.05A and 112.05B, not proposed listings 112.05C and 112.05D. Proposed listing 112.05A and B (final listing 112.05A and C) result in a finding of "meets" based soley on a finding that a child who is mentally retarded demonstrates either the failure to attain specific developmental milestone or an IQ not greater than 59.

As we have indicated previously, we have added a new criterion to listing 112.12 to provide a standard that is comparable to the rules in paragraph B1d of listing 112.02.

Also, in response to this comment and earlier comments which addressed the need for comparable severity thresholds across all age groups, we replaced the phrase "marked impairment" in proposed listing 112.10C (now final listing 112.12C) to ensure comparability within that listing. We did not intend for "marked" in proposed listing 112.10C to be of a different severity threshold than that of the other paragraphs within that listing, e.g., the one-half chronological age cognitive/communicative functioning threshold in proposed 112.10A. However, with the definition of marked in the fourth paragraph of final listing 112.00C, it could be concluded that proposed listing 112.10C had a different severity threshold than the remaining paragraphs in that listing. Therefore, in final listing 112.12C, we replaced "marked impairment" with "an absent or grossly excessive response" to clarify its original intent.

Comment: One commenter stated that proposed listing 112.10 (final listing 112.12) did a "credible job" of tracking DSM-III-R criteria. However, the commenter suggested that some of the language, such as that in subsection D2, could be simplified to more accurately reflect an infant's behavior.

Response: We agree with the commenter. We have therefore revised the language of 112.12D to be simpler and to use terms more specific to infant behavior.

Additional Comments

Comment: One commenter was concerned about the evidence needed to establish a diagnosis under these listings. The commenter stated that we had provided "little room for clinical impressions" but "a lot of room to disqualify a case because the treating source did not know the precise way to support the diagnosis." The commenter recommended that we provide each treating source with clear instructions needed to make a determination under the listings. Similarly, the commenter asked if we would find a child disabled based upon a diagnosis submitted by a treating source unsupported by findings in the paragraphs A and B criteria of any listing. The commenter gave examples of specific impairments that were not mentioned by name in the listings and wondered if children with these disorders could be found disabled.

Response: The kinds of issues raised by this commenter are not specific to the childhood mental listings, but arise in connection with all disability cases. We are in the process of preparing for final publication a separate group of regulations which address, among other things, the responsibilities of our adjudicators in developing the specific information needed from treating sources to complete a record, how and when to obtain information from consultative examinations, and mechanisms for disseminating appropriate information about our evidentiary needs to the medical community.

Our policy, stated in §§ 404.1525(d) and 416.925(d) of the regulations, is that we will not consider an impairment to be a listed impairment solely because it has the diagnosis of a listed impairment. It must also have the findings shown in the listings. On the other hand, we again want to assure this commenter that we will not deny any case simply because a child does not have a listed impairment or because a treating source who is unaware of our evidentiary needs has failed to submit the evidence we need, even though he or she has this information and is willing to provide it. We make every effort to assist claimants—especially children—in obtaining evidence.

Comment: One commenter asked us to include a statement of the "reasons or philosophy for giving disability payments to children." The commenter also expressed concern about whether the payment of benefits to children could be countertherapeutic and a disincentive to the child's family to seek treatment for the child. In a related comment, the commenter asked how we would evaluate cases of children who have treatable impairments but are disabled because they do not receive treatment.

Response: We rejected the recommendation to state in these regulations the "reasons or philosophy" behind the various payments available to children under the Social Security

Act. We pay benefits to children pursuant to laws enacted by the Congress and signed by the President of the United States. Our regulations implement the laws and explain in a practical way how we will abide by them; any statements of "philosophy," such as the commenter suggested, are beyond the purview of these regulations.

When we determine whether a child is disabled, we do not consider matters extraneous to the statute and regulations, such as whether paying benefits will be in the child's best interests. If the medical and other evidence establish that a child is disabled and the child meets all other statutory requirements, we will pay benefits.

With regard to the question of whether we would find a child disabled even if we knew, or thought, that the child could be successfully treated, the answer is that we will, unless the child has failed to follow prescribed treatment and does not have good cause for such failure. We have promulgated specific rules elsewhere in our regulations (see §§ 404.1530 and 416.930) about this issue to direct our adjudicators on how to evaluate such cases.

Other Changes

In view of the changes we are making in 112.00, Mental and Emotional Disorders, of Part B of Appendix 1 of the Listing of Impairments, we are also making a number of conforming and technical changes to other listings in both Parts A and B of the Listing of Impairments.

We are adding a paragraph to the Introduction to Appendix 1 of Subpart P of the Listing of Impairments to indicate that the childhood mental disorders listings will cease to be effective 5 years after publication as a final rule, unless extended by the Secretary or revised and promulgated again.

We are changing the phrase "IQs of 69" to "IQs of 70" in the seventh paragraph of 12.00D.

We are changing the phrase "IQ of 60 to 69 inclusive" to "IQ of 60 through 70" in the 12.05C and 12.05D.

We are changing the phrase "IQ of 69 or less" to "IQ of 70 or less" in listings 11.07A, 109.02B1, 111.02B1, 111.07B1, and 111.08B2.

We are changing the reference in the last sentence of the first paragraph of listing 110.00A2 from "See 112.00B" to "See 112.00C."

We are changing listing 110.07B to read "Mental impairment as described under the criteria in 112.05 or 112.12; or."

Regulatory Procedures

Executive Order 12291

The costs of this regulation are estimated to be as follows:

	1991	1992	1993	1994	1995
Additional SSI recipients	1,000	2,000	2,000	3,000	3,000
Program costs:					
Supplemental Security Income	$2	$6	$9	$12	$14
Medicaid	(1)	$5	$5	$10	$10
Medicare	(1)	(1)	(1)	(1)	(1)
Disability Insurance	(1)	(1)	(1)	(1)	(1)
Administrative savings	(1)	(1)	(1)	(1)	(1)

[1] Negligible

Therefore, the Secretary has determined that this is not a major rule under Executive Order 12291 because these regulations do not meet any of the threshold criteria for a major rule. Therefore, a regulatory impact analysis is not required.

Paperwork Reduction Act

These regulations will impose no new reporting or recordkeeping requirements subject to clearance by the Office of Management and Budget.

Regulatory Flexibility Act

We certify that these regulations will not have a significant economic impact on a substantial number of small entities because they affect only individuals who are applying for title II or title XVI benefits based on disability. Therefore, a regulatory flexibility analysis as provided in Pub. L. 96-354, the Regulatory Flexibility Act, is not required.

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

List of Subjects

20 CFR Part 404

Administrative practice and procedure, Death benefits, Disability benefits, Old-Age, Survivors, and Disability Insurance.

20 CFR Part 416

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

Dated: May 3, 1990.

Gwendolyn S. King,

Commissioner of Social Security.

Approved: August 9, 1990.

Louis W. Sullivan,

Secretary of Health and Human Services.

For the reasons set out in the preamble, part 404, subpart P, of Chapter III of title 20 of the Code of Federal Regulations is amended to read as follows:

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

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

Authority: Secs. 202, 205(a), (b), and (d) through (h), 216(i), 221(a) and (i), 222(c), 223, 225, and 1102 of the Social Security Act, as amended; 42 U.S.C. 402, 405(a), (b), and (d) through (h), 416(i), 421(a) and (i), 442(c), 423, 425, and 1302; sec. 505(a) of Pub. L. 96-265, 94 Stat. 473; secs. 2(d)(2), 5, 6, and 15 of Pub. L. 98-460, 98 Stat. 1797, 1801, 1802, and 1808.

2. Section 404.1520a is amended by revising the second sentence of paragraph (a) introducing text to read as follows:

§ 404.1520a Evaluation of mental impairments.

(a) * * * In addition, in evaluating 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, a special procedure must be followed by us at each level of adminstrative review. * * *

* * * * *

Appendix 1 to Subpart P—[Amended]

3. Appendix 1 to subpart P (Listing or Impairments) is amended by adding a new paragraph before the last paragraph of the introductory text to read as follows:

The mental disorders listing in Part B (112.00) within 5 years. Consequently, the listings in this body system will no longer be effective on December 12, 1995, unless extended by the Secretary or revised and promulgated again.

4. Part A of the Appendix 1 (Listing of Impairments) of subpart P is amended by revising paragraph A of listing 11.07 *Cerebral Palsy* to read as follows:

A. IQ of 70 or less; or

5. Part A of Appendix 1 (Listing of Impairments) of Subpart P is amended by revising the second sentence of the seventh paragraph of 12.00D (*Documentation*) to read as follows:

* * * In this connection, it must be noted that on the WAIS, for example, IQs of 70 and below are characteristic of approximately the lowest 2 percent of the general population. * * *

6. Part A of Appendix 1 (Listing of Impairments) of subpart P is amended by revising paragraph C of listing 12.05 *Mental Retardation and Autism* to read as follows:

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

OR

7. Part A of Appendix 1 (Listing of Impairments) of subpart P is amended by revising the introductory text of paragraph D of listing 12.05 *Mental Retardation and Autism* to read as follows:

D. A valid verbal, performance, or full scale IQ of 60 through 70, or in the case of autism, gross deficits of social and communicative skills, with either condition resulting in two of the following:

8. Part B of Appendix 1 (Listing of Impairments) of subpart P is amended by revising paragraph B1 of listing 109.02 to read as follows:

1. IQ of 70 or less, or

9. Part B of Appendix 1 (Listing of Impairments) of subpart P is amended by revising the last sentence of the first paragraph of A2 of 110.00 (Multiple Body Systems) to read as follows:

2.1 * * * See 112.00C for a discussion of developmental milestone criteria and evaluation of age-appropriate activities.

10. Part B of Appendix 1 (Listing of Impairments) of subpart P is amended by revising paragraph B of introductory text of listing 110.07 Multiple Body Dysfunction to read as follows:

B. Mental impairment as described under the criteria in 112.05 or 112.12; or

11. Part B of Appendix 1 (Listing of Impairments) of subpart P is amended by revising paragraph B1 of listing 111.02 to read as follows:

1. IQ of 70 or less; or

12. Part B of Appendix 1 (Listing of Impairments) of subpart P is amended by revising paragraph B1 of listing 111.07 *Cerebral Palsy* to read as follows:

1. IQ of 70 or least; or

13. Part B of Appendix 1 (Listing of Impairments) of subpart P is amended by revising paragraph B2 of listing 111.08 to read as follows:

2. IQ of 70 or least; or

14. Part B of Appendix 1 (Listing of Impairments) of subpart P is amended by revising 112.00, Mental and Emotional Disorders, to read as follows:

112.00 Mental Disorders

A. *Introduction:* The structure of the mental disorders listings for children under age 18 parallels the structure for the mental disorders listings for adults but is modified to reflect the presentation of mental disorders in children. The listings for mental disorders in children are arranged in 11 diagnostic categories: Organic mental disorders (112.02); schizophrenic, delusional (paranoid), schizoaffective, and other psychotic disorders (112.03); mood disorders (112.04); mental retardation (112.05); anxiety disorders (112.06); somatoform, eating, and tic disorders (112.07); personality disorders (112.08); psychoactive substance dependence disorders (112.09); autistic disorder and other pervasive developmental disorders (112.10); attention deficit hyperactivity disorder (112.11); and developmental and emotional disorders of newborn and younger infants (112.12).

There are significant differences between the listings for adults and the listings for children. There are disorders found in children that have no real analogy in adults; hence, the differences in the diagnostic categories for children. The presentation of mental disorders in children, particularly the very young child, may be subtle and of a character different from the signs and symptoms found in adults. For example, findings such as separation anxiety, failure to mold or bond with the parents, or withdrawal may serve as findings comparable to findings that mark mental disorders in adults. The activities appropriate to children, such as learning, growing, playing, maturing, and school adjustment, are also different from the activities appropriate to the adult and vary widely in the different childhood stages.

Each listing begins with an introductory statement that describes the disorder or disorders addressed by the listing. This is followed (except in listings 112.05 and 112.12) by medical findings (paragraph A criteria), which, if satisfied, lead to an assessment of impairment-related functional limitations (paragraph B criteria). An individual will be found to have a listed impairment when the criteria of both paragraphs A and B of the listed impairment are satisfied.

The purpose of the criteria in paragraph A is to substantiate medically the presence of a particular mental disorder. Specific symptoms and signs under any of the listings 112.02 through 112.12 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.

Paragraph A of the listings is a composite of medical findings which are used to substantiate the existence of a disorder and may or may not be appropriate for children at specific developmental stages. However, a range of medical findings is included in the listings so that no age group is excluded. For example, in listing 112.02A7, emotional liability and crying would be inappropriate criteria to apply to older infants and toddlers, age 1 to attainment of age 3; whereas in 112.02A1, developmental arrest, delay, or regression are appropriate criteria for older infants and toddlers. Whenever the adjudicator decides that the requirements of paragraph A of a particular mental listing are satisfied, then that listing should be applied regardless of the age of the child to be evaluated.

The purpose of the paragraph B criteria is to describe impairment-related functional limitations which are applicable to children. Standardization tests of social or cognitive function and adaptive behavior are frequently available and appropriate for the evaluation of children and, thus, such tests are included in the paragraph B functional parameters. The functional restrictions in paragraph B must be the result of the mental disorder which is manifested by the medical findings in paragraph A.

We have not included separate C criteria for listings 112.03 and 112.06, as are found in the adult listings, because for the most part we do not believe that categories like residual schizophrenia or agoraphobia 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, the adult 12.03C and 12.06C criteria may be used for evaluation of the 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, any one of which, if satisfied, will result in a finding that the child's impairment meets the listing. 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.

It must be remembered that these listings are examples of common mental disorders which are severe enough to find a child disabled. When a child has a medically determinable impairment that is not listed or a combination of impairments no one of which meets a listing, we will make a medical equivalency determination. (See §§ 404.1526 and 416.926.) This determination can be especially important in older infants and toddlers (age 1 to attainment of age 3), who may be too young for identification of a specific diagnosis, yet demonstrate serious

functional limitations. Therefore, the determination of equivalency is necessary to the evaluation of any child's case when the child does not have an impairment that meets a listing.

B. *Need for Medical Evidence:* The existence of a medically determinable impairment of the required duration must be established by medical evidence consisting of symptoms, signs, and laboratory findings (including psychological or developmental test findings). Symptoms are complaints presented by the child. Psychiatric signs are medically demonstrable phenomena which indicate specific abnormalities of behavior, affect, thought, memory, orientation, development, and contact with reality, as described by an appropriate medical source. Symptoms and signs generally cluster together to constitute recognizable mental disorders described in paragraph A of the listings. These findings may be intermittent or continuous depending on the nature of the disorder.

C. *Assessment of Severity:* In childhood cases, as with adults, severity is measured according to the functional limitations imposed by the medically determinable mental impairment. However, the range of functions used to assess impairment severity for children varies at different stages of maturation. The functional areas that we consider are: Motor function; cognitive/communicative function; social function; personal/behavioral function; and concentration, persistence, and pace. In most functional areas, there are two alternative methods of documenting the required level of severity: (1) Use of standardized tests alone, where appropriate test instruments are available, and (2) use of other medical findings. (See 112.00D for explanation of these documentation requirements.) The use of standardized tests is the preferred method of documentation if such tests are available.

Newborn and younger infants (birth to attainment of age 1) have not developed sufficient personality differentiation to permit formulation of appropriate diagnoses. We have, therefore, assigned listing 112.12 for Developmental and Emotional Disorders of Newborn and Younger Infants for the evaluation of mental disorders of such children. Severity of these disorders is based on measures of development in motor, cognitive/communicative, and social functions. When older infants and toddlers (age 1 to attainment of age 3) do not clearly satisfy the paragraph A criteria of any listing because of insufficient developmental differentiation, they must be evaluated under the rules of equivalency. The principles for assessing the severity of impairment in such children, described in the following paragraphs, must be employed.

In defining the severity of functional limitations, two different sets of paragraph B criteria corresponding to two separate age groupings have been established, in addition to listing 112.12, which is for children who have not attained age 1. These age groups are: older infants and toddlers (age 1 to attainment of age 3) and children (age 3 to attainment of age 18). However, the discussion below in 112.00C1, 2, 3, and 4, on the age-appropriate areas of function, is broken down into four age groupings: older infants and toddlers (age 1 to attainment of age 3), preschool children (age 3 to attainment of age 6), primary school children (age 6 to attainment of age 12), and adolescents (age 12 to attainment of age 18). This was done to provide specific specific guidance on the age group variances in disease manifestations and methods of evaluation.

Where "marked" is used 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 the ability to function (based upon age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis. When standardized tests are used as the measure of functional parameters, a valid score that is two standard deviations below the norm for the test will be considered a marked restriction.

1. *Older infants and toddlers (age 1 to attainment of age 3).* In this age group, impairment severity is assessed in three areas: (a) Motor development, (b) cognitive/communicative function, and (c) social function.

a. *Motor development.* Much of what we can discern about mental function in these children frequently comes from observation of the degree of development of fine and gross motor function. Developmental delay, as measured by a good developmental milestone history confirmed by medical examination, is critical. This information will ordinarily be available in the existing medical evidence from the claimant's treating sources and other medical sources, supplemented by information from nonmedical sources, such as parents, who have observed the child and can provide pertinent historical information. It may also be available from standardized testing. If the delay is such that the older infant or toddler has not achieved motor development generally acquired by children no more than one-half the child's chronological age, the criteria are satisfied.

b. *Cognitive/communicative function.* Cognitive/communicative function is measured using one of several standardized infant scales. Appropriate tests for the measure of such function are discussed in 112.00D. Care should be taken to avoid reliance on screening devices, which are not generally considered to be sufficiently reliable instruments, although such devices may provide some relevant data; however, there will be cases in which the results of such tests show such severe abnormalities that further testing will be unnecessary.

For older infants and toddlers, alternative criteria covering disruption in communication as measured by their capacity to use simple verbal and nonverbal structures to communicate basic needs are provided.

c. *Social function.* Social function in older infants and toddlers is measured in terms of the development of relatedness to people (e.g., bonding and stranger anxiety) and attachment to animate or inanimate objects. Criteria are provided that use standard social maturity scales or alternative criteria that describe marked impairment in socialization.

2. *Preschool children (age 3 to attainment of age 6).* For the age groups including preschool children through adolescence, the functional areas used to measure severity are: (a) Cognitive/communicative function, (b) social function, (c) personal/behavioral function, and (d) deficiencies of concentration, persistence, or pace resulting in frequent failure to complete tasks in a timely manner. After 36 months, motor function is no longer felt to be a primary determinant of mental function, although, of course, any motor abnormalities should be documented and evaluated.

a. *Cognitive/communicative function.* In the preschool years and beyond, cognitive function can be measured by standardized tests of intelligence, although the appropriate instrument may vary with age. A primary criterion for limited cognitive function is a valid verbal, performance, or full scale IQ of 70 or less. The listings also provide alternative criteria, consisting of tests of language development or bizarre speech patterns.

b. *Social function.* Social function is measured by an assessment of a child's relationships with parents, other adults, and peers. These relationships are often observed not only at home but also in preschool programs, where the child's interactions with other children and teachers come under daily scrutiny.

c. *Personal/behavioral function.* This function may be measured by a standardized test of adaptive behavior or by careful description of maladaptive or avoidant behaviors. These behaviors are often observed not only at home but also in preschool programs.

d. *Concentration, persistence, and pace.* This function may be measured through observations of the child in the course of standardized testing and in the course of play.

3. *Primary school children (age 6 to attainment of age 12).* The measures of function here are similar to those for preschool-children except that the test instruments may change and the capacity to function in the school setting is supplemental information. Standardized measures of academic achievement, e.g., Wide Range Achievement Test-Revised, Peabody Individual Achievement Test, etc., may be helpful in assessing cognitive impairment. Problems in social functioning, especially in the area of peer relationships, are often observed firsthand by teachers and school nurses. As described in 112.00D, *Documentation*, school records are an excellent source of information concerning function and standardized testing and should always be sought for school-age children.

As it applies to primary school children, the intent of the functional criterion described in paragraph B2d, i.e., deficiencies of concentration, persistence, or pace resulting in failure to complete tasks in a timely manner, is to identify the child who cannot adequately function in primary school because of a mental impairment. Although grades and the need for special education

placement are relevant factors which must be considered in reaching a decision under paragraph B2d, they are not conclusive. There is too much variability from school district to school district in the expected level of grading and in the criteria for special education placement to justify reliance solely on these factors.

4. *Adolescents (age 12 to attainment of age 18).* Functional criteria parallel to those for primary school children (cognitive/communicative; social; personal/behavioral; and concentration, persistence, and pace) are the measure of severity for this age group. Testing instruments appropriate to adolescents should be used where indicated. Comparable findings of disruption of social function must consider the capacity to form appropriate, stable, and lasting relationships. If information is available about cooperative working relationships in school or at part-time or full-time work, or about the ability to work as a member of a group, it should be considered when assessing the child's social and personal/behavioral functioning. Markedly impoverished social contact, isolation, withdrawal, and inappropriate or bizarre behavior under the stress of socializing with others also constitute comparable findings.

In adolescents, the intent of the functional criterion described in paragraph B2d is the same as in primary school children. However, other evidence of this functional impairment may also be available, such as from evidence of the child's performance in work or work-like settings.

D. *Documentation:* 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 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.

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 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.

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.

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.

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.

A reference to standardized psychological testing indicates the use of a psychological test that has appropriate characertistics of validity, reliability, and norms, administered individually by psychologist, psychiatrist, pediatrician, or other physician specialist qualified by training and experience to perform such an evaluation. Psychological tests are best considered as sets of tasks or questions designed to elicit particular behaviors when presented in a standardized manner.

The salient characteristics of a good test are: (1) Validity, i.e., the test measures what it is supposed to measure, as determined by appropriate methods; (2) reliability, i.e., the consistency of results obtained over time with the same test and the same individual; and (3) appropriate normative data, i.e., individual test scores must be comparable to test data from other individuals or groups of a similar nature, representative of that population. In considering the validity of a test result, any discrepancies between formal test results and the child's customary behavior and daily activities should be duly noted and resolved.

Tests meeting the above requirements are acceptable for the determination of the conditions contained in these listings. The psychologist, psychiatrist, pediatrician, or other physician specialist administering the test must have a sound technical and professional understanding of the test and be able to evaluate the research documentation related to the intended application of the test.

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 and the Revised Stanford-Binet scales. Thus, IQ's below 60 reflect a level of intellectual functioning below 99.5 percent of the general population, and IQ's of 70 and below are characteristic of approximately the lowest 2 percent of the general population. IQ's obtained from standardized tests that deviate significantly from a mean of 100 and standard deviation of 15 require conversion to the corresponding percentile rank in the general population so that the actual degree of impairment 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 IQ's are provided, as on the Wechsler series, the lowest of these is used in conjunction with listing 112.05.

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.

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.

In conjunction with clinical examinations, sources may report the results of screening tests, i.e., tests used for gross determination of level of functioning. These tests do not have high validity and reliability and generally are not considered appropriate primary evidence for disability determinations. These screening instruments may be useful in uncovering potentially serious impairments, but generally must be supplemented by the use of formal, standardized psychological testing for the purposes of a disability determination, unless the determination is to be made on the basis of findings other than psychological test data; however, there will be cases in which the results of screening tests show such obvious abnormalities that further testing will clearly be unnecessary.

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.

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.

Exceptions to formal standardized psychological testing may be considered when a psychologist, psychiatrist, pediatrician, or other physician specialist who is qualified by training and experience to perform such an evaluation is not readily available. In such instances, appropriate medical, historical, social, and other information must be reviewed in arriving at a determination.

Exceptions may also be considered in the case of ethnic/cultural minorities where the native language or culture is not principally English-speaking. In such instances, psychological tests that are culture-free, such as the Leiter International Performance Scale or the Scale of Multi-Culture Pluralistic Assessment (SOMPA) may be substituted for the standardized tests described above. Any required tests must be administered in the child's principal language. When this is not possible, appropriate medical, historical, social, and other information must be reviewed in arriving at a determination. Furthermore, in evaluating mental impairments in children from a different culture, the best indicator of severity is often the level of adaptive functioning and how the child performs activities of daily living and social functioning.

"Neuropsychological testing" refers to the administration of standardized tests that are reliable and valid with respect to assessing impairment in brain functioning. It is intended that the psychologist or psychiatrist using these tests will be able to evaluate the following functions: Attention/concentration, problem-solving, language, memory, motor, visual-motor and visual-perceptual, laterality, and general intelligence (if not previously obtained).

E. *Effect of Hospitalization or Residential Placement*: As with adults, children with mental disorders may be placed in a variety of structured settings outside the home as part of their treatment. Such settings include, but are not limited to, psychiatric hospitals, developmental disabilities facilities, residential treatment centers and schools, community-based group homes, and workshop facilities. The reduced mental demands of such structured settings may attenuate overt symptomatology and superficially make the child's level of adaptive functioning appear better than it is. Therefore, the capacity of the child to function outside highly structured settings must be considered in evaluating impairment severity. This is done by determining the degree to which the child can function (based upon age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis outside the highly structured setting.

On the other hand, there may be a variety of causes for placement of a child in a structured setting which may or may not be directly related to impairment severity and functional ability. Placement in a structured setting in and of itself does not equate with a finding of disability. The severity of the impairment must be compared with the requirements of the appropriate listing.

F. *Effects of Medication*: Attention must be given to the effect of medication on the child's signs, symptoms, and ability to function. While psychoactive medications may control certain primary manifestations of a mental disorder, e.g., hallucinations, impaired attention, restlessness, or hyperactivity, such treatment may or may not affect the functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the psychoactive medications, particular attention must be focused on the functional limitations which may persist. These functional limitations must be considered in assessing impairment severity.

Psychotropic medicines used in the treatment of some mental illnesses may cause drowsiness, blunted affect, or other side effects involving other body systems. Such side effects must be considered in evaluating overall impairment severity.

112.01 Category of Impairments, Mental

112.02 *Organic Mental Disorders*: Abnormalities in perception, cognition, affect, or behavior associated with dysfunction of the brain. The history and physical examination or laboratory tests, including psychological or neuropsychological tests, demonstrate or support the presence of an organic factor judged to be etiologically related to the abnormal mental state and associated deficit or loss of specific cognitive abilities, or affective changes, or loss of previously acquired functional abilities.

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

A. Medically documented persistence of at least one of the following:

1. Developmental arrest, delay or regression; or

2. Disorientation to time and place; or

3. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or

4. Perceptual or thinking disturbance (e.g., hallucinations, delusions, illusions, or paranoid thinking); or

5. Disturbance in personality (e.g., apathy, hostility); or

6. Disturbance in mood (e.g., mania, depression); or

7. Emotional liability (e.g., sudden crying); or

8. Impairment of impulse control (e.g., disinhibited social behavior, explosive temper outbursts); or

9. Impairment of cognitive function, as measured by clinically timely standardized psychological testing; or

10. Disturbance of concentration, attention, or judgment;

AND

B. Select the appropriate age group to evaluate the severity of the impairment:

1. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the following:

a. Gross or fine motor development at a level generally acquired by children no more than one-half the child's chronological age, documented by:

(1) An appropriate standardized test; or

(2) Other medical findings (see 112.00C); or

b. Cognitive/communicative function at a level generally acquired by children no more than one-half the child's chronological age, documented by:

(1) An appropriate standardized test; or

(2) Other medical findings of equivalent cognitive/communicative abnormality, such as the inability to use simple verbal or nonverbal behavior to communicate basic needs or concepts; or

c. Social function at a level generally acquired by children no more than one-half the child's chronological age, documented by:

(1) An appropriate standardized test; or

(2) Other medical findings of an equivalent abnormality of social functioning, exemplified by serious inability to achieve age-appropriate autonomy as manifested by excessive clinging or extreme separation anxiety; or

d. Attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas covered by a., b., or c., as measured by an appropriate standardized test or other appropriate medical findings.

2. For children (age 3 to attainment of age 18), resulting in at least two of the following:

a. Marked impairment in age-appropriate cognitive/communicative function, documented by medical findings (including consideration of historical and other information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized psychological tests, or for children under age 6, by appropriate tests of language and communication; or

b. Marked impairment in age-appropriate social functioning, documented by history and medical findings (including consideration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized tests; or

c. Marked impairment in personal/behavioral function, as evidenced by:

(1) Marked restriction of age-appropriate activities of daily living, documented by history and medical findings (including consideration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, appropriate standardized tests; or

(2) Persistent serious maladaptive behaviors destructive to self, others, animals, or property, requiring protective intervention; or

d. Deficiencies of concentration, persistence, or pace resulting infrequent failure to complete tasks in a timely manner.

112.03 *Schizophrenic, Delusional (Paranoid), Schizoaffective, and Other Psychotic Disorders:* Onset of psychotic features, characterized by a marked disturbance of thinking, feeling, and behavior, with deterioration from a previous level of functioning or failure to achieve the expected level of social functioning.

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

A. Medically documented persistence, for at least 6 months, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or

2. Catatonic, bizarre, or other grossly disorganized behavior; or

3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech; or

4. Flat, blunt, or inappropriate effect; or

5. Emotional withdrawal, apathy, or isolation;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.04 *Mood Disorders:* Characterized by a disturbance of mood (referring to a prolonged emotion that colors the whole psychic life, generally involving either depression or elation), accompanied by a full or partial manic or depressive syndrome.

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

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Major depressive syndrome, characterized by at least five of the following, which must include either depressed or irritable mood or markedly diminished interest or pleasure:

a. Depressed or irritable mood; or

b. Markedly diminished interest or pleasure in almost all activities; or

c. Appetite or weight increase or decrease, or failure to make expected weight gains; or

d. Sleep disturbance; or

e. Psychomotor agitation or retardation; or

f. Fatigue or loss of energy; or

g. Feelings of worthlessness or guilt; or

h. Difficulty thinking or concentrating; or

i. Suicidal thoughts or acts; or

j. Hallucinations, delusions, or paranoid thinking;

OR

2. Manic syndrome, characterized by elevated, expansive, or irritable mood, and at least three of the following:

a. Increased activity or psychomotor agitation; or

b. Increased talkativeness or pressure of speech; or

c. Flight of ideas or subjectively experienced racing thoughts; or

d. Inflated self-esteem or grandiosity; or

e. Decreased need for sleep; or

f. Easy distractibility; or

g. Involvement in activities that have a high potential of painful consequences which are not recognized; or

h. Hallucinations, delusions, or paranoid thinking;

OR

3. Bipolar or cyclothymic syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently or most recently characterized by the full or partial symptomatic picture of either or both syndromes);

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.05 *Mental Retardation:* Characterized by significantly subaverage general intellectual functioning with deficits in adaptive functioning.

The required level of severity for this disorder is met when the requirements in A, B, C, D, E, or F are satisfied.

A. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02;

OR

B. Mental incapacity evidenced by dependence upon others for personal needs (grossly in excess of age-appropriate dependence) and inability to follow directions such that the use of standardized measures of intellectual functioning is precluded;

OR

C. A valid verbal, performance, or full scale IQ of 59 or less;

OR

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

OR

E. A valid verbal, performance, or full scale IQ of 60 through 70 and:

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 either paragraphs B1a or B1c of 112.02; or

2. For children (age 3 to attainment of age 18), resulting in at least one of paragraphs B2b or B2c or B2d of 112.02;

OR

F. Select the appropriate age group:

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 additional and significant limitations 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 additional and significant limitations of function.

112.06 *Anxiety Disorders:* In these disorders, anxiety is either the predominant disturbance or is experienced if the individual attempts to master symptoms, e.g., confronting the dreaded object or situation in a phobic disorder, attempting to go to school in a separation anxiety disorder, resisting the obsessions or compulsions in an obsessive compulsive disorder, or confronting strangers or peers in avoidant disorders.

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 at least one of the following:

1. Excessive anxiety manifested when the child is separated, or separation is threatened, from a parent or parent surrogate; or

2. Excessive and persistent avoidance of strangers; or

3. Persistent unrealistic or excessive anxiety and worry (apprehensive expectation), accompanied by motor tension, autonomic hyperactivity, or vigilance and scanning; or

4. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

5. Recurrent severe panic attacks, manifested by a sudden unpredictable onset of intense apprehension, fear, or terror, often with a sense of impending doom, occurring on the average of at least once a week; or

6. Recurrent obsessions or compulsions which are a source of marked distress; or

7. Recurrent and intrusive recollections of a traumatic experience, including dreams, which are a source of marked distress;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.07 *Somatoform, Eating, and Tic Disorders:* Manifested by physical symptoms for which there are no demonstrable organic findings or known physiologic mechanisms; or eating or tic disorders with physical manifestations.

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 one of the following:

1. An unrealistic fear and perception of fatness despite being underweight, and persistent refusal to maintain a body weight which is greater than 85 percent of the

average weight for height and age, as shown in the most recent edition of the *Nelson Textbook of Pediatrics*, Richard E. Behrman and Victor C. Vaughan, III, editors, Philadelphia: W. B. Saunders Company; or

2. Persistent and recurrent involuntary, repetitive, rapid, purposeless motor movements affecting multiple muscle groups with multiple vocal tics; or

3. Persistent nonorganic disturbance of one of the following:

a. Vision; or

b. Speech; or

c. Hearing; or

d. Use of a limb; or

e. Movement and its control (e.g., coordination disturbance, psychogenic seizures); or

f. Sensation (diminished or heightened); or

g. Digestion or elimination; or

4. Preoccupation with a belief that one has a serious disease or injury;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.08 *Personality Disorders:* Manifested by pervasive, inflexible, and maladaptive personality traits, which are typical of the child's long-term functioning and not limited to discrete episodes of illness.

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

A. Deeply ingrained, maladaptive patterns of behavior, associated with one of the following:

1. Seclusiveness or autistic thinking; or

2. Pathologically inappropriate suspiciousness or hostility; or

3. Oddities of thought, perception, speech, and behavior; or

4. Persistent disturbances of mood or affect; or

5. Pathological dependence, passivity, or aggressiveness; or

6. Intense and unstable interpersonal relationships and impulsive and exploitative behavior; or

7. Pathological perfectionism and inflexibility;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.09 *Psychoactive Substance Dependence Disorders:* Manifested by a cluster of cognitive, behavioral, and physiologic symptoms that indicate impaired control of psychoactive substance use with continued use of the substance despite adverse consequences.

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 at least four of the following:

1. Substance taken in larger amounts or over a longer period than intended and a great deal of time is spent in recovering from its effects; or

2. Two or more unsuccessful efforts to cut down or control use; or

3. Frequent intoxication or withdrawal symptoms interfering with major role obligations; or

4. Continued use despite persistent or recurring social, psychological, or physical problems; or

5. Tolerance, as characterized by the requirement for markedly increased amounts of substance in order to achieve intoxication; or

6. Substance taken to relieve or avoid withdrawal symptoms;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.10 *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 the development of 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 pervasive developmental disorders, both of the following:

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

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

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraphs B2 of 112.02.

112.11 *Attention Deficit Hyperactivity Disorders:* Manifested by developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity.

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 all three of the following:

1. Marked inattention; and

2. Marked impulsiveness; and

3. Marked hyperactivity;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.12 *Developmental and Emotional Disorders of Newborn and Younger Infants (Birth to attainment of age 1):* Developmental or emotional disorders of infancy are evidenced by a deficit or lag in the areas of motor, cognitive/communicative, or social functioning. These disorders may be related either to organic or to functional factors or to a combination of these factors.

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

A. Cognitive/communicative functioning generally acquired by children no more than one-half the child's chronological age, as documented by appropriate medical findings (e.g., in infants 0–6 months, markedly diminished variation in the production or imitation of sounds and severe feeding abnormality, such as problems with sucking swallowing, or chewing) including, if necessary, a standardized test;

OR

B. Motor development generally acquired by children no more than one-half the child's chronological age, documented by appropriate medical findings, including if necessary, a standardized test;

OR

C. Apathy, over-excitability, or fearfulness, demonstrated by an absent or grossly excessive response to one of the following:

1. Visual stimulation; or

2. Auditory stimulation; or

3. Tactile stimulation;

OR

D. Failure to sustain social interaction on an ongoing, reciprocal basis as evidenced by:

1. Inability by 6 months to participate in vocal, visual, and motoric exchanges (including facial expressions); or

2. Failure by 9 months to communicate basic emotional responses, such as cuddling or exhibiting protest or anger; or

3. Failure to attend to the caregiver's voice or face or to explore an inanimate object for a period of time appropriate to the infant's age;

OR

E. Attainment of developmental or function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas (i.e., cognitive/communicative, motor, and social), documented by appropriate medical findings, including if necessary, standardized testing.

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

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

Authority: Secs. 1102, 1614(a), 1169, 1631 (a) and (d)(1), and 1633 of the Social Security Act; 42 U.S.C. 1302, 1382c(a), 1382h, 1383 (a) and (d)(1), and 1383b; secs. 2, 5, 6, and 15 of Pub. L. 98-460, 98 Stat. 1794, 1801, 1802, and 1808.

16. Section 416.920a is amended by revising the second sentence of paragraph (a) introductory text to read as follows:

§ 416.920a Evaluation of mental impairments

(a) * * * In addition, in evaluating 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, a special procedure must be followed by us at each level of administrative review. * * *

* * * * *

[FR Doc. 90-28744 Filed 12-11-90; 8:45 am]
BILLING CODE 4190-29-M

SUMMARY OF NEW LISTINGS FOR DOWN SYNDROME AND OTHER SERIOUS HEREDITARY, CONGENITAL, OR ACQUIRED DISORDERS

THE REVISED REGULATION CONTAINS TWO NEW LISTINGS:
- **LISTING 110.06 FOR THE EVALUATION OF DOWN SYNDROME**
- **LISTING 110.07 FOR OTHER SERIOUS HEREDITARY, CONGENITAL, OR ACQUIRED DISORDERS**

PREVIOUS RULES
In the past, most children with Down Syndrome and other congenital, acquired or hereditary conditions were evaluated primarily under the mental listings. However, many of these children also have problems involving other body systems such as the musculoskeletal, cardiovascular, or neurological body systems. Therefore, the effect of such disorders needed to be assessed under the medical criteria in the listing for that body system as well.

NEW RULES (Published in Federal Register, December 12, 1990)
Now there are specific listing criteria for Down Syndrome and other serious hereditary, congenital, or acquired disorders.

NEW LISTINGS - CATEGORY - MULTIPLE BODY SYSTEMS - 110.01

LISTING 110.06 - DOWN SYNDROME (EXCLUDING MOSAIC DOWN SYNDROME)
A child meets this listing when the diagnosis of non-mosaic Down Syndrome is established by both clinical and laboratory findings. Documentation must include:
- Confirmation of a positive diagnosis
  --clinical description AND
  --definitive laboratory tests; i.e., chromosomal analysis
- Medical evidence that is persuasive that a positive diagnosis has been confirmed by lab testing is acceptable in lieu of a copy of the actual report.

LISTING 110.07 - HEREDITARY, CONGENITAL, OR ACQUIRED CONDITION
This listing is for claims involving multiple body dysfunction due to any confirmed hereditary, congenital, or acquired condition. Some examples of these conditions are (but not exclusive):
- Mosaic Down Syndrome
- Fetal alcohol syndrome
- Phenylketonuria (PKU)
- Severe, chronic neonatal infections

Again, the diagnosis must be confirmed by both clinical and laboratory findings.

Prepared By:
Social Security Administration
Office of Disability
Office of Medical Evaluation
December 27, 1990

SUMMARY OF CHANGES IN REVISED CHILDHOOD MENTAL LISTINGS

The medical criteria in Section 112.00 of the Listing of Impairments, which are located in Part B of Appendix 1 of Subpart P of Part 404 of title 20 of the Code of Federal Regulations were revised by publication of final regulations in the Federal Register, December 12, 1990. We will list the revisions and in some cases show what the old listing displayed.

A. We updated the medical terminology because we wanted the revised Childhood Mental listings to reflect the terminology currently used by mental health professionals who treat children. The source used is the Revised Third Edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders--the DSM-III-R.

B. There are more Childhood Mental listings making it more specifically related to distinct types of mental disorders. Since fewer conditions are included under the same listing there is an increase in the number of listings from four to eleven. Many of the titles of the revised listings are the same as or very similar to the ones in the adult mental listings. A quick review of the Childhood Mental listings is as follows:

112.02 Organic Mental Disorders - This is revised from the old 112.02. It covers the same impairments though that were under the old listing.

112.03 Schizophrenic, Delusional (Paranoid), Schizoaffective, and Other Psychotic Disorders - It now addresses all of the disorders which are listed in the title.

112.04 Mood Disorders - It covers what the title says -- mood disorders (also known as "Affective Disorders").

112.05 Mental Retardation - Has the same title as the former listing 112.05. The listing has been expanded from 3 paragraphs to 6 and the upper IQ limit has been raised from 69 to 70.

112.06 Anxiety Disorders - This is a new listing covering anxiety disorders specific to children.

112.07 Somatoform, Eating, and Tic Disorders - This is new for Childhood Mental. It's a little broader than the adult listing. New listing 112.07 covers under one heading various mental disorders which have physical manifestations, such as anorexia nervosa.

112.08 Personality Disorders - New listing 112.08 addresses personality disorders. The features of these disorders are pervasive, inflexible, and maladaptive personality traits that are typical of a child's long-term functioning and not limited to discrete episodes of illness.

112.09 Psychoactive Substance Dependence Disorders - This new listing is different from the current adult listing. The childhood listing is a stand-alone. It has its own diagnostic criteria which are based on those in the DSM-III-R.

112.10 Autistic Disorder and Other Pervasive Development Disorders - This new listing covers disorders characterized by qualitative deficits in development of reciprocal social interaction, in the development of verbal and nonverbal communication skills, and imaginative activity.

112.11 Attention Deficit Hyperactivity Disorder - This is a new listing for children with Attention Deficit Hyperactivity Disorder. The essential features of this disorder are developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity.

112.12 Developmental and Emotional Disorders of Newborn and Younger Infants (Birth to Attainment of Age 1) - This new listing addresses very young children who have not developed sufficient personality to permit the formulation of an appropriate diagnosis. This listing also contains criteria for evaluation of functional deficits in infants.

C. Most of the listings have paragraph A and paragraph B criteria. Paragraph A criteria are diagnostic because they are used to substantiate the mental disorder described in the capsule definition. Paragraph B criteria on the other hand contain the functional requirements of listing-level severity. To avoid unnecessary duplication, the "B" criteria are set forth only in Listing 112.02, but apply to all listings with "B" criteria.

D. Another significant change are the 3 sets of functional criteria:
Set 1: Children Under Age 1;
Set 2: Children Aged 1 to 3;
Set 3: Children Aged 3 to 18.

E. There are 4 Domains or Functional Areas covered in the age group 3 to 18, as specified in paragraph B2 of listing 112.02:
1. Cognitive/Communicative;
2. Social;
3. Personal/Behavioral;
4. Concentration, Persistence, and Pace.

F. In the Introduction, to better clarify age-appropriateness, children in the age groups of Age 3 through 18 are divided into 3 groups:
Preschool Age 3 to 6;
Primary School Age 6 to 12;
Adolescent Age 12 to 18.

G. The functional criteria for children in the age 1 to 3 group are expressed in terms of developmental delay. The domains as specified in paragraph B1 of listing 112.02 are:
1. Motor;
2. Cognitive/Communicative;
3. Social.

Prepared By:
Social Security Administration
Office of Disability
Office of Medical Evaluation
December 27, 1990

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Washington, D.C. 20201

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HHS-393