

MEDICAL EXPERT HANDBOOK

Social Security Administration
Office of Hearings Operations
Office of the Chief Administrative Law Judge

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Preface

Thank you for becoming a medical expert (ME) for the Office of Hearings Operations (OHO). This handbook provides the basic information you will need when you participate in administrative law judge (ALJ) hearings. The handbook explains Social Security's disability programs, the appeals process we use, your role and responsibilities, and technical information you must know.

We hope that you will find this handbook interesting and useful. If you have any comments or questions about it, please write or call:

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In General-Disability Overview, Medical Experts, and the Social Security Appeals Process

What are Social Security’s Disability Programs?

The Social Security Administration (SSA or agency) administers [several programs](#) that pay disability benefits to individuals. Under [Title II](#) of the Social Security Act (Act),¹ disability benefits may be paid to people who work in “covered” employment or self-employment and who pay sufficient Social Security taxes² to become “insured” for disability benefits. There are also disability benefits that may be paid to the disabled adult children of insured workers who retire, die, or are themselves disabled, and disability benefits that may be paid to certain disabled widows and widowers of insured workers. We often refer to these benefits as “Title II” disability benefits in reference to the title of the Act that provides for these benefits.

We administer another disability program under [Title XVI](#) of the Act. Title XVI provides payments of Supplemental Security Income (SSI) to individuals who are age 65 or older, or blind or disabled, and who have limited income and resources. Title XVI (SSI) payments are funded from general tax revenues and not from Social Security taxes, because eligibility for Title XVI programs is not based on payment of Social Security taxes.

Where Do You Fit In?

We use medical experts (ME) to provide evidence at hearings before an administrative law judge (ALJ).³ At this level of our *administrative review process* people ask for a *de novo* hearing before an ALJ regarding a prior determination on their claim for benefits under the Social Security disability program.

The administrative review process is our term for a multi-step process of application (or other initial determination) and appeals.

¹ The [Social Security Act](#), 42 U.S.C. 301 *et seq.*, is the federal law governing Social Security Benefits.

² Federal Insurance Contributions Act (FICA) or Self-Employment Contributions Act (SECA) taxes.

³ Hearing office staff select MEs in rotation, subject to the ME’s availability and based upon a request from the ALJ for a particular medical specialty. HALLEX [I-2-5-36](#).

In general, there are four levels in the SSA administrative review process:

- Initial determination
- Reconsideration
- ALJ hearing
- Appeals Council review

After they complete the administrative review process, claimants who are still dissatisfied with our final decision generally have the right to appeal to federal district court.

At the initial and reconsideration levels, State agencies (often called “Disability Determination Services” or *DDSs*) make disability determinations for us. Although DDSs are State agencies, we fully fund their operations, and they make disability determinations using our rules. DDSs obtain medical and other evidence they need to make these determinations, including arranging for independent medical examinations, which we call “consultative examinations” (CE), when they need them. In general, the determination at the DDS is made by a team consisting of one or more medical professionals (a *medical consultant* or *psychological consultant*; and sometimes a *medical advisor*) and a lay *disability examiner*.⁴ While DDS adjudicators routinely contact claimants to collect information, they usually do not meet with claimants. The DDS determination is based on an evaluation of the evidence in the claimant’s case file.

Most people who qualify for disability benefits are found disabled by the DDS at the initial or reconsideration levels. People whose claims are denied or

⁴ Depending on where you work, you may encounter variations to the foregoing procedures. For example, in some states there is no reconsideration level, and in some states a special kind of disability examiner called a “single decisionmaker” (SDM) may make the initial determination alone in some cases without getting input from a medical or psychological consultant. This is because we are testing variations to our usual processes in some states. However, section 832 of the [Bipartisan Budget Act of 2015](#), Pub. L. 114-74, 129 Stat. 584, 613, affects the use of an SDM in that the SDM testing modification under 20 CFR 404.906(b)(2) and 416.1406(b)(2) is scheduled to end by the end of calendar year 2018, as well as the other modification being tested, the disability examiner authority, which allows the examiners to make fully favorable determinations in quick disability determinations (QDD) and compassionate allowance (CAL) claims under 20 CFR 404.1615(c)(3) and 416.1015(c)(3). See [81 FR 73027](#) (10/24/16) and [81 FR 58544](#) (8/25/16).

who are otherwise dissatisfied with their determinations⁵ may appeal their claims to the ALJ hearing level, the level at which you will be asked to provide evidence.

At certain times, we also review whether people who are already receiving disability benefits continue to be disabled. When such people are dissatisfied with our determination about whether they are still disabled, they too can appeal. The process is somewhat different from the initial claims process, but like the initial process, it has an ALJ hearing level, and you may be asked to provide evidence for such a hearing. We provide more information about this step on page 28.

What is an “ME”?

MEs are physicians, psychologists, speech-language pathologists, and certain other types of medical professionals who provide impartial expert opinion evidence that an ALJ considers when making a decision about disability. An ALJ may use an ME before, during, or after a hearing. As an ME, you will usually testify by telephone, although you may be asked to testify in person or by video conferencing (VTC) technology.⁶ Sometimes you may provide opinions in writing by answering written questions called *interrogatories* (which we explain on page 31). You must be prepared to cite specific evidence from the record to support your testimony.

For more information, please refer to [Hearings, Appeals, and Litigation Law \(HALLEX\) manual](#) section [I-2-5-32](#).

What is an ALJ?

An ALJ is the official who presides at our administrative hearings. Our ALJs perform a number of duties, including administering oaths, examining witnesses, receiving evidence, making findings of fact, and deciding whether an individual is or is not disabled. Our ALJs are SSA employees and hold hearings on behalf of the Commissioner of SSA.

What is “Disability” for Social Security Programs?

The Act provides two definitions of disability. One definition applies to all Title II claims and to claims of individuals age 18 and older under Title XVI

⁵ For example, some people are found disabled at the DDS level, but not for the entire period they claimed.

⁶ See 20 CFR [404.936\(c\)\(2\)](#) and [416.1436\(c\)\(2\)](#).

(SSI). There is a separate definition for children (individuals who have not attained age 18) under the Title XVI (SSI) program.

The general definition of disability under Title II and for adults under Title XVI is:

[The] inability to engage in any substantial gainful activity⁷ by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.⁸

Under Title II of the Act, a person may also be disabled based on blindness, which is defined as:

[C]entral visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered . . . as having a central visual acuity of 20/200 or less.⁹

The Title XVI (SSI) program contains an identical definition of the term “blindness” for purposes of determining whether an individual is eligible for benefits based on blindness under the Title XVI (SSI) program.

The definition of disability for children under Title XVI is:

[A] medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.¹⁰

As with an adult, a child is not disabled if he or she is engaging in substantial gainful activity.

⁷ The concept of substantial gainful activity is explained in more detail on page 16.

⁸ See sections [223\(d\)\(1\)\(A\)](#) and [1614\(a\)\(3\)\(A\)](#) of the Act.

⁹ There is also a statutory definition of blindness under Titles II and XVI, but under Title II, blindness is a kind of “disability,” while under Title XVI it is a category separate from “disability.” There is also a separate definition of disability under Title II for people who are at least 55 years old and blind. These technical, legal distinctions do not affect your work as a medical expert. See sections [216\(i\)\(1\)](#) and [1614 \(a\)\(2\)](#) of the Act.

¹⁰ Children can also qualify for Title XVI (SSI) benefits based on “blindness.”

There is more detail to the definition of disability in the Act, and we have detailed regulations and other rules defining all the terms in the Act and explaining our requirements for determining disability. We describe these rules in more specificity beginning on page 13.

What Happens at the ALJ Hearing?¹¹

In the vast majority of cases at the hearing level, ALJs hold hearings at which claimants, and sometimes other people,¹² appear and testify. This hearing is generally the first time in the administrative review process that the claimant has a chance to see and talk to the person who will make the disability decision. However, a claimant may ask the ALJ to make a decision without an in-person hearing, based only on the documents in his or her case record. You may be asked to provide evidence in both kinds of cases, either by testifying at a hearing or by submitting written responses to written questions called interrogatories.¹³

At the hearing, the ALJ will have all of the documentary information that the DDS considered at the initial and reconsideration levels. The claimant generally also has submitted more evidence in connection with his or her appeal. Although ALJ hearings are more informal than court proceedings, the ALJ will swear in the claimant and any other witnesses, including you. Most claimants are represented by an attorney or other representative, but there is no requirement that the claimant have a representative. The hearing is non-adversarial; that is, there is no representative for SSA who argues against the claim. The ALJ is responsible for assisting the claimant and following the Act, regulations, and other rules, and is an impartial decisionmaker.

The ALJ will ask you questions before you testify to establish your independence and impartiality, and your medical qualifications and competence to testify. If the ALJ does not already have it, you should provide him or her with a written résumé or curriculum vitae summarizing your experience and background which the ALJ will enter into the case record as evidence. The ALJ will also ask you whether the résumé or curriculum vitae is accurate and up to date, and will likely ask you whether you are familiar with applicable SSA regulations and other rules.¹⁴ The ALJ

¹¹ See page 10 of this handbook for additional information about prehearing review and about preliminary questions the ALJ will ask you to establish your expertise and impartiality.

¹² Such as family members and medical and vocational expert witnesses.

¹³ Interrogatories are explained on page 31.

¹⁴ See page 8.

will also ask the claimant and his or her representative, if any, whether they object to your testifying.

In most cases, you will testify by telephone. Increasingly, we have been using VTC technology to improve our capacity to hold timely hearings. In some cases, all of the participants in the hearing will be present in the same room for the hearing. Regardless of how the testimony is given, the ALJ will question the claimant, you, and any other witnesses. The claimant and his or her representative will also have an opportunity to question you and other witnesses and to make arguments to the ALJ. The ALJ has the authority to determine the propriety of any questions asked. The agency makes an audio recording of the hearing.

You may be present throughout the entire hearing, or the ALJ may decide that you should come into the hearing at a specific time. If you are not present throughout the hearing, the ALJ may summarize the relevant testimony and any evidence he or she received that you do not already have.

After the hearing, the ALJ will generally consider all the evidence and issue a written decision. Sometimes the ALJ will get more information after the hearing. For example, the ALJ, the claimant, or the claimant's representative may obtain more recent medical records that were not available before the hearing was held. The ALJ may then ask you to answer interrogatories. These may be the ALJ's own questions or questions submitted by the claimant or his or her representative. The ALJ may also decide to hold another hearing, called a *supplemental hearing*.

What is the Appeals Council?

The Appeals Council is the last level of appeal within SSA. There are no local Appeals Council offices. The Appeals Council's headquarters is in Falls Church, Virginia; it also has offices in Arlington, Virginia and Baltimore, Maryland.

If the claimant is dissatisfied with the ALJ's decision, he or she may request Appeals Council review. The Appeals Council may grant, deny, or dismiss the request for review. If the Appeals Council denies the request to review the ALJ's decision, the ALJ's decision will become SSA's final decision. If the Appeals Council grants the request for review, it may make its own decision reversing, modifying, or affirming the ALJ's decision. In that case, the Appeals Council's decision becomes SSA's final decision.

In most cases, when the Appeals Council grants a request for review, it does not make its own decision. Instead, the Appeals Council *remands* (*i.e.*, returns) the case to the ALJ for additional action, including possibly a new hearing and decision. You may be asked to testify at an ALJ hearing that results from an Appeals Council remand.

What are Federal Court Appeals?

If the claimant is dissatisfied with SSA's final decision in the administrative review process, he or she may file a civil action in a federal district court. The district court may affirm, modify, or reverse SSA's final decision. In some cases, the district court will remand the case to SSA for further proceedings, which may include a new ALJ hearing and decision. You may be asked to testify at an ALJ hearing that results from a district court remand.

The claimant can continue to appeal his or her case in the federal courts to a United States Court of Appeals ("circuit court") and eventually to the Supreme Court of the United States, although this is extremely rare. At each of these levels, it is possible that the court will remand the case to SSA for a new hearing at which you may be asked to testify.

Role of the ME

Responsibilities of the ME

The ALJ's primary reason for seeking the advice of an ME is to gain a better understanding of the medical evidence in the case. An ME provides both factual information and expert opinion based on his or her medical or psychological knowledge and knowledge of SSA's rules. For example, you should be familiar with:

- The medical evidence regarding the specific claimant at issue. SSA provides this evidence to you. You should be prepared to cite to specific evidence to support your testimony.
- What a *medically determinable impairment* is, and SSA's definitions of *symptoms, signs, and laboratory findings*.
- SSA's requirement to consider the combined effects of impairments.
- SSA's Listing of Impairments (commonly referred to as the "listings").
- SSA's definitions of "meeting" and "medically equaling" specific listings.¹⁵ If prompted by the ALJ, you should be prepared to cite specific listings that may apply to the claimant, **and** the specific evidence to support whether a claimant meets or medically equals the listing(s).
- The concept of *residual functional capacity* (RFC) for all cases except Title XVI (SSI) child cases, including the types of evidence and the kinds of physical and mental work-related limitations SSA considers in assessing RFC.
- In cases involving Title XVI (SSI) claimants under age 18, the area(s) of pediatric medicine appropriate to the claim, typical child development and functioning, and SSA's policy of "functionally equaling" the listings.
- SSA's concept of "duration" of disability.

¹⁵ The listings are part of SSA's regulations, but we also publish them separately. See the List of References at the end of this handbook for citations.

You will provide evidence by answering questions posed by the ALJ, the claimant, and the claimant's representative. You may be asked to answer questions about medical issues that could be decisive in a case, such as whether a claimant's impairment(s) meets or medically equals a specific listing.¹⁶ Also, for claims filed on or after March 27, 2017, you may be asked for your medical opinion regarding what the claimant can still do despite his or her impairments and whether the claimant has one or more impairment-related limitations or restrictions in the following abilities:

- the ability to perform physical demands of work activities, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping, or crouching);
- the ability to perform mental demands of work activities, such as understanding; remembering; maintaining concentration, persistence, or pace; carrying out instructions; or responding appropriately to supervision, co-workers, or work pressures in a work setting;
- the ability to perform other demands of work, such as seeing, hearing, or using other senses; and
- the ability to adapt to environmental conditions, such as temperature extremes or fumes.¹⁷

You must cite to specific evidence to support your testimony. You should *never* comment on non-medical matters, such as whether you believe a claimant can do his or her previous work, or offer an opinion about whether a claimant is "disabled," even if you are asked.

If you have any questions—*e.g.*, about an aspect of a claimant's testimony—or if you need more information, you should inform the ALJ. The ALJ will decide whether the information is pertinent and how it should be elicited. You should never conduct any type of physical or mental status examination of the claimant during the hearing, and should refuse to perform such an examination if asked.

¹⁶ We explain the concepts of "meeting" and "medically equaling" a listing later in this handbook.

¹⁷ See 20 CFR [404.1513](#)(a)(2) and [416.913](#)(a)(2). For claims filed before March 27, 2017, you may be asked to answer questions regarding your medical opinion about the nature and severity of a claimant's impairment(s), including symptoms, diagnosis and prognosis, what the claimant can still do despite his or her impairment(s), and the claimant's physical or mental restrictions. See 20 CFR [404.1527](#)(a)(1) and [416.927](#)(a)(1).

The ALJ will not rely on your testimony alone to make his or her decision about disability or to make medical findings that go into that decision. The ALJ will consider your testimony, along with the other evidence in the case record, including the claimant's testimony at the hearing and any other testimony. Your testimony may also help the ALJ determine whether he or she needs more evidence in order to make a decision.

Conduct of the ME

You should conduct yourself as if you are testifying in a civil or criminal court. Give complete answers to the questions you are asked. Whenever possible, you should phrase your answers in lay terms. To ensure impartiality, you must avoid any substantive contact with the ALJ before or after the hearing, and avoid face-to-face or telephone contact with the claimant or his or her representative, both before and after the hearing. You must disqualify yourself if you believe that you cannot be completely impartial, have prior knowledge of the case, or have had prior contact with the claimant. However, the ALJ will not disqualify you merely because you testified in a previous case regarding the same claimant.

Pre-Hearing Preparation

The ALJ will generally provide you with relevant portions of the case file before the hearing. (You must fully understand the importance of proper handling of this information; please read the next section "Protecting Personally Identifiable Information (PII)" carefully.) This information will give you a chance to become familiar with the medical aspects of the claim. It will also prepare you to answer the kinds of medical questions, such as questions about the nature and duration of the claimant's impairment(s) and functional limitations, treatment, and side effects, that you can expect at the hearing. If, after reviewing this information, you believe that you need more information to provide adequate testimony about the claimant's medical history, current treatment, prognosis, and the other issues we discuss in the following sections of this handbook, you should prepare a written list of your questions and refer them to the ALJ.

Generally, the period under consideration for establishment of disability in initial claims begins with the date the claimant alleges that he or she became disabled (commonly referred to as the *alleged onset date*, or AOD) and goes through the date of the ALJ's decision. However, there are situations requiring evaluation of the claimant's medical condition(s) before

the AOD;¹⁸ or starting at a later time. The ALJ will advise you of the period under consideration.

Protecting Personally Identifiable Information (PII)

SSA defines PII as any information that can be used to distinguish or trace an individual's identity (such as his or her name, Social Security number, biometric records, etc.) alone, or when combined with other personal or identifying information that is linked or linkable to a specific individual (such as date and place of birth, mother's maiden name, etc.). SSA is mandated to safeguard and protect the PII entrusted to the agency¹⁹ and to immediately report breaches to the Department of Homeland Security.

The claimant information the ALJ provides to you, which may be in paper or electronic form, must be protected against loss, theft, or inadvertent disclosure. Failure to take the proper steps to protect this information, or failure to immediately report to SSA when you suspect PII is compromised, could adversely affect your standing and may result in termination of your contract. To maintain good standing with SSA, follow these instructions to reduce the risk of PII loss, theft, or inadvertent disclosure:

- Ensure your employees or associates are fully aware of these procedures and the importance of protecting PII.
- If you are expecting to receive claimant information from SSA, and you have not received it within the expected time frame, immediately notify your SSA contact or alternate contact.
- Secure all SSA claimant information in a locked container, such as a locked filing cabinet, or while in transit, in a locked briefcase.
- Once you arrive at your destination, always move PII to the most secure location. Do not leave PII locked in a car trunk overnight.
- When viewing a claimant's file, prevent others in the area from viewing the file's contents.
- Ensure PII is appropriately returned or, upon receiving SSA's approval, destroyed when no longer needed. Media must be destroyed in a manner that prevents unauthorized disclosure of sensitive information.

¹⁸ For example, as we noted earlier in this handbook, under Title II a worker's insured status can expire. In this situation, the worker can still qualify for disability benefits, but must show that he or she was disabled on or before this *date last insured*.

¹⁹ See section [1106](#) of the Act and [5 U.S.C. 552a](#).

Appropriate destruction techniques include shredding, pulverizing, and burning.

In the event of a loss, theft, or disclosure you must *immediately* notify your primary SSA contact or alternate contact. Report the following information, as completely and accurately as possible:

- Your contact information
- A description of the loss, theft, or disclosure, including the approximate time and location of the incident
- A description of safeguards used, as applicable
- Whether you have contacted, or been contacted, by any external organizations (i.e., other agencies, law enforcement, press, etc.), and whether you have filed any other reports
- Any other pertinent information

If you are unable to reach your SSA contacts, call SSA's National Network Service Center (NNSC) toll free at 1-877-697-4889. Provide them with the information outlined above. Record the Change, Asset, and Problem Reporting System (CAPRS) number which the NNSC will assign to you. Limit disclosure of the information and details about the incident to only those with a need to know. The security/PII loss incident reporting process will ensure that SSA's reporting requirements are met and that security/PII loss incident information is only shared appropriately.

Delay in reporting may adversely affect SSA's ability to investigate and resolve the incident and may lead to suspension or termination of your contract.

Determining Disability

You may be asked to give evidence in any kind of disability case under the programs we administer. Most often, you will be giving evidence in cases of insured workers under Title II and adults claiming SSI disability benefits under Title XVI, or “concurrent” claims for both types of benefits.²⁰ Less often, you may testify at hearings concerning the other kinds of disability cases described below.

Detailed Definitions of Disability

The Act defines disability in all Title II claims and in adult Title XVI claims as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months.²¹ The latter part of the definition is the “duration requirement.”

For Social Security purposes, a physical or mental impairment is a physical or mental medical condition. A *medically determinable impairment* is an impairment that results from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Note that, while SSA considers a claimant’s symptoms, the law specifies that there must be “objective medical evidence” to establish the existence of the impairment.

“Inability to engage in any substantial gainful activity” means that a claimant's impairment(s) must not only prevent him or her from performing previous work but also from making an adjustment to any other kind of substantial gainful work that exists in significant numbers in the national economy, considering his or her age, education, and previous work

²⁰ On January 18, 2017, SSA published final rules, “Revision to Rules Regarding the Evaluation of Medical Evidence,” in the Federal Register ([82 FR 5844](#)). The final rules became effective on March 27, 2017. For claims filed on or after March 27, 2017, all of the revised rules apply. For claims filed before March 27, 2017, some of the prior rules will continue to apply. Where applicable, the agency regulations set out when the revised rules apply. The ALJ will provide guidance in the event that these changes would affect your testimony.

²¹ As we have already noted, there is also a statutory definition of blindness under Titles II and XVI, but under Title II, blindness is a kind of “disability,” while under Title XVI it is a category separate from “disability.” There is also a separate definition of disability under Title II for people who are at least 55 years old and blind. These technical, legal distinctions do not affect your work as a medical expert. We provided the statutory definition of blindness on page 4 of this handbook.

experience. The law specifies that it is irrelevant whether the work exists in the immediate area where the claimant lives, whether a specific job vacancy exists, or whether the claimant would be hired if he or she applied for work. In other words, the question is not whether the claimant can *get* a job, only whether he or she can *do* it.

Title XVI of the Act defines disability for children as a “medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.”²² The Act also states that the child must not be engaging in any substantial gainful activity. An impairment(s) causes marked and severe functional limitations if it meets or medically equals a specific listing, or if it functionally equals²³ the listings. We have separate medical listings for Title XVI (SSI) childhood disability claims.

In all cases under Titles II and XVI, including SSI childhood disability claims, we cannot find that a claimant is disabled if drug addiction or alcoholism is a “contributing factor material to” the determination of disability. This requirement means that, if we find that the claimant is disabled, we must still deny the claim if we determine that the claimant would not be disabled if he or she stopped using drugs or alcohol.²⁴ An ALJ may ask for your opinions about what medical findings would persist or what limitations a claimant would still have if he or she stopped using drugs or alcohol.

²² See [1614\(a\)\(3\)\(C\)\(i\)](#) of the Act.

²³ The policy of functional equivalence applies only to children (individuals under age 18) and only in the Title XVI (SSI) program.

²⁴ Although agency regulations refer to “drug addiction or alcoholism,” SSA interprets this terminology to include any “substance use disorder” defined in the latest edition of the American Psychiatric Association’s [Diagnostic and Statistical Manual of Mental Disorders](#) (the DSM-V). See 20 CFR [404.1535](#) and [404.935](#).

Determining Initial Disability for All Title II and Adult Title XVI Cases

The Sequential Evaluation Process

We have extensive regulations and other rules that interpret the provisions of the Act described above and instruct our ALJs and other adjudicators on how to determine whether a claimant is disabled. The rules interpreting the basic definition of disability for adults provide a five-step *sequential evaluation process* that we use to determine whether a claimant is disabled. We use different sequential processes to determine initial eligibility of children under Title XVI and whether beneficiaries continue to be disabled (*Continuing Disability Review*, or CDR, and redeterminations of the disability of individuals who qualified for Title XVI (SSI) benefits as children when they reach age 18).

The sequential evaluation process requires the adjudicator to follow the steps in order, and at each step either make a decision, in which case the evaluation stops, or decide that a decision cannot be made at that step. When the ALJ determines that a decision cannot be made at a given step, he or she goes on to the next step(s) until a decision can be made. 20 CFR [404.1520](#) and [416.920](#).²⁵

Note that for each of the first four steps described below, we explain that the ALJ may stop and make a decision. However, with some exceptions,²⁶ ALJs generally do not make their decisions at the hearing. ALJs generally issue a written decision sometime after the hearing. ALJs generally ask for information relevant to all of the steps of the sequential evaluation process at the hearing. The description below explains the steps that an ALJ follows when making disability decisions.

²⁵ "20 CFR" is a reference to Title 20 of the [Code of Federal Regulations](#) (CFR). The CFR is a compilation of all federal regulations, and Title 20 contains SSA's regulations. Regulation section numbers that start with the number "404" are Title II regulations; those that start with the number "416" are for Title XVI. See the List of References at the end of this handbook for more information about our regulations and other rules.

²⁶ The most common exception is under a rule we have that allows an ALJ to announce at the hearing that he or she has found that the claimant is disabled. ALJs cannot announce denial decisions at the hearing.

STEP 1: Is the claimant engaging in substantial gainful activity?²⁷

Substantial gainful activity (SGA) is work activity that: (a) involves doing significant physical or mental activities; and (b) is usually done for pay or profit, whether or not a profit is realized. SGA is most often measured by gross monthly earnings. When countable monthly earnings are above a prescribed amount, which increases each year, the claimant is generally considered to be engaging in SGA. Self-employed individuals are engaging in SGA when they perform significant services in a business, work comparable to unimpaired individuals, or work which is worth the prescribed monthly SGA amount. Since the basic definition of disability is “inability to engage in any substantial gainful activity,” we find that a claimant who is actually doing SGA is “not disabled” regardless of the severity of his or her impairment(s).

STEP 2: Does the claimant have a “severe” impairment?

The ALJ will generally consider two issues at this step: whether the claimant has a “medically determinable impairment” and, if so, whether the medically determinable impairment is “severe” and meets the duration requirement.

A *medically determinable impairment* is an impairment that results from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. To establish a medically determinable impairment, SSA’s rules require *objective medical evidence* from an *acceptable medical source (AMS)*.

20 CFR [404.1521](#) and [416.921](#).

- *Objective medical evidence* includes signs, laboratory findings, or both.
- For all claims, an *acceptable medical source* is a medical source who is a licensed physician (medical or osteopathic doctor), licensed or psychologist (including licensed or certified school psychologists, or other licensed or certified individual with another title who performs the same function as a school psychologist in a school setting, for impairments of intellectual disability, learning disabilities, and borderline intellectual functioning only), licensed optometrist (for vision disorders, or measurement of visual acuity and visual fields only), licensed podiatrist (for foot, or foot and ankle podiatric disorders only), and qualified speech language pathologist (for speech and language disorders only). For claims filed on or after March 27, 2017, additional AMSs include licensed audiologists (for hearing loss,

²⁷ 20 CFR [404.1574](#), [404.1575](#), [416.974](#), and [416.975](#) provide evaluation guides for determining whether work is SGA.

auditory processing disorders, and balance disorders only), licensed advance practice registered nurses, or other licensed advanced practice nurses with another title (acting within the licensed scope of practice), and licensed physician assistants (acting within the licensed scope of practice).²⁸

The word “severe” is a term of art in SSA’s rules. An impairment or a combination of impairments is “severe” if it significantly limits a claimant’s ability to do one or more basic work activities needed to do most jobs. See 20 CFR [404.1520\(c\)](#), [404.1521](#), [416.920\(c\)](#), and [416.921](#). Abilities and aptitudes necessary to do most jobs include physical functions, such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, handling, seeing, hearing, and speaking. They also include mental functions, such as understanding, carrying out and remembering simple instructions; using judgment; responding appropriately to supervision, co-workers, and usual work situations; and dealing with changes in a routine work setting. 20 CFR [404.1521](#) and [416.921](#).²⁹

The threshold for determining that an impairment is “severe” is low. Our rules explain that an impairment is not “severe” if it is only a slight abnormality which has no more than a minimal effect on a claimant's ability to do basic work activities. Social Security Ruling (SSR) [85-28](#).³⁰ Also, even if none of the claimant’s impairments considered separately is “severe,” the ALJ must consider whether the claimant’s *combination* of impairments is “severe.”

Symptoms are the claimant’s own description of his or her physical or mental impairment. Such statements alone are not enough to establish that there is a medically determinable physical or mental impairment. There must also be objective medical evidence, *i.e.*, signs or laboratory findings from an acceptable medical source. See [SSR 16-3p](#).

²⁸ 20 CFR 404.1502 and 416.902.

²⁹ Note that a person with a physical impairment may have a limitation in a mental function. For example, persistent pain may interfere with a person’s mental ability to concentrate. Partly for this reason, you may be asked to comment on a claimant’s mental limitation even if you have a specialty in an area of somatic medicine. Moreover, if you are a physician, we expect that you have the training to comment to some extent on issues involving mental disorders.

³⁰ Although SSRs do not have the force and effect of the law or regulations, they are binding on all components of SSA, including ALJs and other adjudicators. See the List of References at the end of this handbook, or click [here](#), for a list of important SSRs that you may need to consult.

Signs are one or more anatomical, physiological, or psychological abnormalities that can be observed apart from the claimant’s statement of symptoms. Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, *e.g.*, abnormalities of behavior, mood, thought, memory, orientation, development, or perception. They must also be shown by observable facts that can be medically described and evaluated.

Laboratory findings are one or more anatomical, physiological, or psychological phenomena that can be shown by the use of medically acceptable laboratory diagnostic techniques. Diagnostic techniques include chemical tests (such as a blood test), electrophysiological studies (such as electrocardiogram and electroencephalogram), medical imaging studies (such as x-rays), and psychological tests.

If the claimant does not have a medically determinable impairment, or if the claimant’s medically determinable impairment(s) is not “severe,” the claimant is not disabled and the analysis stops. If the claimant has at least one “severe” medically determinable impairment or a number of non-severe impairments that are severe when considered in combination, the ALJ goes to the next step.

STEP 3: Does the claimant have an impairment(s) that meets or medically equals a listed impairment in the Listing of Impairments?

The ALJ will find that the claimant is disabled when the objective medical evidence and other findings associated with the claimant’s medically determinable impairment(s) satisfies all of the criteria for an impairment described in the [Listing of Impairments](#) (Listings) set out in Appendix 1, Subpart P of Part 404 of our regulations,³¹ and meets the duration requirement. Disability may also be established when the claimant has an impairment or a combination of impairments with findings that do not meet the specific requirements of a listed impairment but are medically equivalent in severity to the findings of a listed impairment and meet the duration requirement.

The Listings describe, for each “body system,” medically determinable impairments and associated findings that we consider severe enough to

³¹ We print the listings only in Part 404 (the Title II regulations) to save space in the CFR. They also apply to Title XVI.

prevent an adult from doing “any gainful activity”³² regardless of his or her age, education, or work experience. Most of the listed impairments are permanent or expected to result in death. For some listings, we state a specific period of time for which the impairment(s) will meet the listing.³³ For all others, the evidence must show that the impairment meets the duration requirement; that is, that it has lasted or can be expected to last for a continuous period of at least 12 months. See 20 CFR [404.1525](#) and [416.925](#).³⁴

The Listings are in two parts. [Part A](#) contains 14 body systems, with listings that apply to individuals age 18 and over. We may also use some listings in Part A to evaluate impairments in individuals under age 18 if the disease processes have a similar effect on adults and children. [Part B](#) contains 15 body systems, with listings that apply only to individuals under age 18.³⁵

Each body system in the Listings is also in two parts: a general introduction and specific impairment listings. The introductory text includes definitions of key concepts used in that section, and may also include substantive rules, such as requirements for specific medical findings to establish the existence of a listed impairment. The evidence used to satisfy any listing must be objective medical evidence from an acceptable medical source (see Step 2, above, for further discussion of objective medical evidence).

The specific listings follow the introduction in each body section, after the heading “Category of Impairment.” An impairment(s) is said to *meet* a listing when the evidence shows that the findings in a specific listing and any

³² Note that this is a stricter standard from the standard in the basic definition of disability for adults (“any substantial gainful activity”). The Listings describe a higher level of severity because they do not require that the adjudicator to consider the vocational factors of previous work experience, age, and education. (The adjudicator considers these vocational factors only if the case requires analysis at step 5 of the sequential evaluation process.)

³³ For example, some cancer listings specify that an individual will be considered to be under a disability for a specified minimum period of time, such as 12 months, 18 months, or 24 months, depending on the specific type of cancer.

³⁴ Unrelated severe impairments cannot be combined to meet the 12-month duration requirement. 20 CFR [404.1523](#) and [416.923](#).

³⁵ Please note [significant changes](#) to the mental listings (12.00/112.00) became effective January 17, 2017. Changes include updated regulatory language to align with the DSM V, and new listings 12.11/112.11, 12.12/112.13, 12.15/112.15, and 112.14. The revised listings reorganize and simplify listing 12.05/112.05, and remove listing 12.09. In addition, the revised listings update the “paragraph B” and “paragraph C” criteria, discussed below in a more extensive explanation of evaluating mental disorders.

additional requirements in the introductory text are satisfied. A medical diagnosis alone is insufficient to meet a listing.³⁶

Agency rules also provide for the possibility of “medical equivalence” with a specific listing because the Listings do not include every possible impairment or combination of impairments a person could have or every possible medical finding that would indicate an inability to do any gainful activity even for impairments that are included in the listings.

To find that an impairment is medically equivalent to a listed impairment, the findings associated with the impairment(s) must be at least of equal medical significance to the required criteria. If the claimant’s specific impairment is not listed, the ALJ will compare the findings for the claimant’s impairment with the listed impairment most like, or most analogous to, the claimant’s impairment to decide whether the claimant’s impairment is medically equal. If the claimant has more than one impairment, and none of them meet or medically equal a listed impairment, the ALJ will compare the findings associated with all of the claimant’s impairments with those for closely analogous listed impairments. If the findings related to the claimant’s impairments are at least of equal medical significance to those of a listed impairment, the ALJ will find that the claimant’s impairment is *medically equivalent* to the analogous listing, or that it *medically equals* that listing. 20 CFR [404.1526](#) and [416.926](#).

You will frequently be asked to provide testimony to assist the ALJ in determining whether the claimant’s impairment(s) meets or medically equals a listing. You must be prepared to identify specific listings that are appropriate with regard to the claimant’s impairment(s); and to identify the specific evidence in the case record that shows whether the impairment(s) satisfies the listing’s specific requirements.³⁷

If the claimant has an impairment(s) that meets or medically equals a listing and meets the duration requirement, the ALJ will find that the claimant is disabled and the analysis stops. If not, the ALJ will go on to the next step of the sequential evaluation process.

³⁶ As you become familiar with the listings, you will note that there are some listings that are met simply by having a confirmed diagnosis of a particular disorder, such as non-mosaic Down syndrome—listing 10.06 for adults. However, even in these circumstances we must have objective medical evidence in the case record that establishes the diagnosis.

³⁷ See SSR [17-2p](#).

Residual Functional Capacity (RFC)

If the claimant is not engaging in SGA and has at least one severe impairment that does not meet or medically equal a listing, the ALJ must assess the claimant's RFC before going on to step 4. The RFC assessment is a description of the physical and mental work functions the claimant can still perform in a work setting on a sustained basis despite his or her impairment(s).

The RFC is the *most* that the claimant can still do despite the limitations caused by his or her impairment(s), including any related physical or mental symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness. In order to assess the claimant's RFC, the ALJ may ask you to give your opinion regarding the claimant's functional limitations and restrictions caused by medically determined impairments. If the claimant has more than one medically determinable impairment, the ALJ must consider limitations from *all* of the claimant's impairments, including limitations from any medically determinable impairment that is not "severe."³⁸

You will frequently be asked your opinion about claimants' functional abilities, limitations, and restrictions. When you provide your opinion on these concepts, be prepared to cite specific evidence to support your testimony. The ALJ's assessment of a claimant's RFC will not rely solely on your testimony. The ALJ will base his or her findings on all of the relevant medical and other evidence, including your testimony.³⁹ 20 CFR [404.1545](#) and [416.945](#). The ALJ will specify what information he or she wants you to testify about. Since you will not have examined the claimant, it will be especially important that you explain your opinion based on the information in the case record and your medical expertise.

There are two important additional agency policies about RFC you must know:

³⁸ As you saw under step 2, the agency's definition of "severe" is based on work functioning. Therefore, an impairment that is not "severe" might still cause some slight or minimal limitations in functioning, and those limitations might affect the claimant's ability to do some jobs or job functions.

³⁹ Other relevant evidence can include the claimant's own statements and the statements of other people who know the claimant.

- First, the RFC is generally what an individual can still do on a “regular and continuing basis,” 8 hours a day, for 5 days a week, or an equivalent work schedule; that is, in a work setting.⁴⁰
- Second, the RFC considers only the effects of the claimant’s medically determinable impairment(s). By rule, the ALJ cannot consider the claimant’s age, sex, body habitus,⁴¹ or overall conditioning when determining RFC, but only limitations that result from documented medically determinable impairments.

See SSR [96-8p](#).

The ALJ evaluates the claimant’s ability to meet the physical, mental, sensory, and other requirements of work. The ALJ considers physical abilities, including: exertional activities (e.g., sitting, standing, walking, lifting, carrying, pushing, and pulling); postural activities (e.g., stooping, climbing); manipulative activities (e.g., reaching, handling); vision; the physical aspects of communication (hearing, speaking); and environmental factors (e.g., tolerance of temperature extremes or dusty environments). The ALJ will also consider mental functions (e.g., understanding and remembering instructions of various complexities, concentrating, getting along with coworkers and the public, responding appropriately to supervision, and responding to changes in the workplace). Of course, the ALJ will ask you to provide your opinions only about functioning that is within your area of training and expertise.

STEP 4: Can the claimant do any past relevant work?

After assessing the RFC, the ALJ decides whether the claimant is able to do any *past relevant work* (PRW), either as the claimant actually performed it or as it is generally performed in the national economy. The term “PRW” is generally defined as the work the claimant performed at the SGA level within the last 15 years (or before certain ending dates specified in our rules) and includes only jobs that lasted long enough for the claimant to learn to do them.

⁴⁰ In rare cases, the ALJ may ask for your opinion about functioning the claimant can do in a part-time setting. However, unless the ALJ specifies otherwise, you should assume that you are being asked for your opinion about how the claimant can function for 8 hours a day, 5 days a week, and on a sustained basis. If you are not sure, you should ask the ALJ before providing your opinion.

⁴¹ Note, however, that SSA may consider obesity to be a medically determinable impairment. See SSR [02-1p](#), also cited in the List of References at the end of this handbook.

The ALJ will make this determination by comparing the claimant's RFC with the requirements of these jobs. If there is PRW that the claimant can still do, the claimant is not disabled and the analysis stops. If the claimant cannot do any PRW, or does not have any PRW, the ALJ will continue to the last step. You should never comment on whether you believe a claimant can do his or her PRW, even if you are asked.

STEP 5: Can the claimant do other work?

If the ALJ finds the claimant can no longer do any PRW, or the claimant does not have any PRW, the ALJ must finally consider whether the claimant can make an adjustment to other work, that exists in significant numbers in the national economy, at the last step of the sequential evaluation process. The ALJ must consider the claimant's RFC, and the vocational factors of age, education, and past relevant work experience. The ALJ will use a complex set of agency rules, which include special rules in [Appendix 2](#) of Subpart P of Part 404 (called the *Medical-Vocational Guidelines*, but often referred to as *the grid rules* or *the grids*). The ALJ will often call on another expert witness, called a *vocational expert* (VE), to provide testimony regarding whether work exists in the national economy, that an individual with a particular RFC would be able to do. Again, you should never comment on whether you believe a claimant can work, even if you are asked.

At this last step of the sequential evaluation process, the ALJ must decide whether the claimant is disabled. If the claimant can make an adjustment to other work in the national economy, he or she is not disabled. If the claimant cannot make an adjustment to other work in the national economy, he or she is disabled.

NOTE: In cases where there is medical evidence of drug addiction or alcoholism (DAA), the ALJ may be required to also determine whether the DAA is a contributing factor that is "material" to the determination of disability. In these cases, the ALJ must also determine whether the claimant would still be disabled if he or she stopped using drugs or alcohol.

Therefore, the ALJ may ask you for your opinions about changes in medical findings and in physical or mental functional limitations (or both) that might occur if the claimant stopped substance use. If the evidence in the case shows that the claimant has DAA, you should be prepared to answer these kinds of questions and, wherever possible, to cite evidence in the case record that supports your opinion, such as evidence from a period of nonuse.

Determining Initial Disability under Title XVI for Individuals under Age 18 (Title XVI (SSI) Childhood Cases)

For Title XVI disability purposes, a "child" is an individual who has not attained age 18. As we have already noted, Title XVI provides a different statutory definition of disability for children than for adults, based on "marked and severe functional limitations." The sequential evaluation process for children who seek Title XVI (SSI) benefits is different from the process for adults. The standard of disability for children who seek Title XVI (SSI) benefits is stricter than the standard of disability for adults. SSA regulations provide that the child's impairment(s) will be found to result in "marked and severe functional limitations" if it is of *listing-level severity*; that is, for a child to be found disabled, his or her impairment(s) must meet or medically equal a specific listing, or "functionally equal the listings" (see below). The child's impairment must also meet the same duration requirement as in the adult standard.

The three steps in the Title XVI (SSI) childhood sequential evaluation process are:

Step 1: Is the child engaging in substantial gainful activity (SGA)?

The term SGA has the same meaning for children as for adults.

- If yes, the ALJ will find that the child is not disabled.
- If no, the ALJ goes to step 2.

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

For a child, the definition of a "severe" impairment is essentially the same as for adults except that, instead of referring to "basic work-related activities," the definition for children refers to "functional limitations." Therefore, a "severe impairment(s)" for a child is defined as more than a slight abnormality or a combination of slight abnormalities that causes more than minimal functional limitations considering appropriate functioning for the child's age. 20 CFR [416.924\(c\)](#). Whenever we consider a child claimant's functioning, we must consider it in comparison to children of the same age who do not have impairments.

- If the child does not have a medically determinable impairment(s), or if the impairment(s) is not severe, the ALJ will find that the child is not disabled.
- If the child has a severe impairment, the ALJ goes to step 3.

Step 3: Does the child’s impairment(s) meet or medically equal a listing, or functionally equal the listings?

The rules for determining whether an impairment(s) meets or medically equals the criteria of a specific listing are the same for children as for adults. As already noted, in evaluating whether the impairment(s) of a child meets or medically equals a specific listing, the ALJ will first consider Part B of the Listings; if the child's impairment(s) does not meet or medically equal an impairment in that part, the ALJ will consider whether there is an appropriate listing under Part A that the impairment(s) could meet or medically equal. 20 CFR [416.925\(b\)\(2\)](#) and [416.926](#).

- If the child’s impairment(s) meets or medically equals a specific listing, and satisfies the duration requirement, the ALJ will find that the child is disabled.
- If the impairment(s) does not meet or medically equal any specific listing, the ALJ will determine whether it *functionally equals the listings*.

Functional equivalence to the listings is a concept used only in evaluating disability for persons under age 18 in Title XVI cases. Unlike “meets” and “medical equivalence,” the determination is not made by reference to specific listings or any other provisions within the Listings; it is a standard of disability based on “listing-level severity.” Our rules further define this term as requiring *marked* limitations in two of six domains of functioning or *extreme* limitation in one. Our regulations define the domains as broad areas of functioning intended to capture all of what a child can or cannot do. They are:

- (1) acquiring and using information;
- (2) attending and completing tasks;
- (3) interacting and relating with others;
- (4) moving about and manipulating objects;
- (5) caring for yourself; and
- (6) health and physical well-being.

20 CFR [416.926a](#).

We also define the severity terms “marked” and “extreme” for functional equivalence in our rules. 20 CFR [416.926a](#)(e). The definitions are provided in a variety of different ways, such as in descriptive terms and in terms of scores on standardized tests.

In assessing whether the child has “marked” or “extreme” limitations, the ALJ must consider the functional limitations from all medically determinable impairments, including any impairments that are not “severe.” 20 CFR [416.926a](#)(a). The rules also require consideration of the “interactive and cumulative effects” of the child’s impairment or multiple impairments in any and all affected domains. For example, while it is obvious that multiple impairments can have effects in more than one domain, the rules provide that a single impairment may have effects in more than one domain. Likewise, combinations of impairments need not have effects in multiple domains; in some cases, the combination of impairments may have an effect in only one domain. These principles, the domains, and other important information you must know if you testify at hearings involving Title XVI (SSI) child claimants are described in more detail in 20 CFR [416.924a](#) and [416.926a](#) and in [SSRs](#) 09-1p through 09-8p.⁴²

In assessing whether a child has limitations, the ALJ will determine how appropriately, effectively, and independently the child performs activities compared to other children of the same age who do not have impairments. We provide guidance about, and examples of, typical and atypical functioning in each of the domains for children in four age groups⁴³ in 20 CFR [416.926a](#)(g) through (l) and [SSRs](#) 09-3p through 09-8p. If you testify in childhood disability claims, you must be familiar with these rules and guidance; however, you should also provide your own pediatric expertise. As with adult cases, you must cite specific evidence from the record to support your testimony.

NOTE: As you have already seen, we use the term “severe” in our sequential evaluation processes for adults and children. As you become more familiar with our program, you will notice that we also use the term “marked” in several rules, especially in some listings and in the policy of

⁴² See the List of References at the end of this handbook.

⁴³ Newborns and young infants (birth to attainment of age 1), older infants and toddlers (age 1 to attainment of age 3), preschool children (age 3 to attainment of age 6), school-age children (age 6 to attainment of age 12), and adolescents (age 12 to attainment of age 18). We also have rules for adjusting chronological age for prematurity. See 20 CFR [416.924b](#).

functional equivalence.⁴⁴ Our rules specify that the *phrase* “marked and severe functional limitations” that is used to define the standard of disability in the Act for children claiming Title XVI (SSI) benefits does not have the same meaning as the *separate terms* “marked” and “severe” we use in other rules. 20 CFR [416.902](#).

⁴⁴ For example, we use the term “marked” in the mental disorders and immune system disorders listings for adults and children.

Determining Continuing Disability

In addition to adjudicating appeals involving a claimant's initial entitlement to disability benefits, ALJs also adjudicate appeals of determinations that individuals who were previously awarded disability benefits are no longer "disabled." There are two basic types of cases in this category.

- From time to time we review the continuing disability of both adults and children under Titles II and XVI.⁴⁵ We refer to these cases as *continuing disability reviews* (CDR) or "cessation" cases.
- Title XVI also requires that we *redetermine* the disabilities of individuals who qualified for Title XVI (SSI) benefits as children when they reach age 18 using the adult rules for initial disability claims. We refer to these cases as *age-18 redetermination* cases.

In these type of cases, the DDS will have already determined that the individual's disability ended on a specific date. The ALJ then considers whether the individual's disability actually ended on that date, at a later date, or not at all. In some—but not all—cases, the ALJ will consider whether the individual has become disabled again even if the disability did end in the past. The ALJ will give you instructions, and you will be asked questions, appropriate to the issues of the specific case.

We conduct CDRs for adults and children. In both cases, we use different sequential evaluation processes than in initial claims for benefits, because the Act contains different standards for these reviews. 20 CFR [404.1594](#), [416.994](#), and [416.994a](#). In a CDR, the ALJ must determine whether the evidence shows *medical improvement* in the individual's condition from the most recent favorable medical decision that the claimant was disabled or continued to be disabled. There are few differences between the opinions you will be asked to give in these cases and the opinions you are asked to give in cases involving initial applications for benefits.

CDRs and Medical Improvement

The Act provides that we generally cannot find that an individual's disability has ended unless we have evidence showing that:

⁴⁵ We review cases at frequencies ranging from as little as 6 months after the decision date, up to about 7 years, depending on the probability that the individual's impairment(s) will improve to the point of non-disability. We do not send all individuals' cases to the DDS for a medical review. In many cases, we determine through a questionnaire we call a "mailer" that the individual's disability continues.

- The impairment(s) upon which we last found him or her to be disabled or still disabled has medically improved,⁴⁶
- The medical improvement is “related to the ability to work” in the case of adults,⁴⁷ *and*
- The individual is not disabled under the basic definition of disability.

To determine whether medical improvement has occurred, the ALJ will look only at the impairment(s) the individual had at the time of our most recent favorable disability decision; that is, either our initial decision that the individual was disabled or, if more recent, our last determination that the individual was still disabled. We call this the *comparison point decision* (CPD). The ALJ will compare the medical severity of the CPD impairment(s) at the time of the DDS’s cessation determination to the severity of those impairments at the time of the CPD. 20 CFR [404.1594\(b\)\(7\)](#), [416.994\(b\)\(1\)\(vii\)](#), and [416.994a\(b\)\(1\)](#). Medical improvement is any decrease in the medical severity of those CPD impairments as shown by changes (improvement) in the signs, symptoms, and laboratory findings associated with the impairment(s). 20 CFR [404.1594\(c\)\(2\)](#), [416.994\(b\)\(2\)](#), and [416.994a\(c\)](#).⁴⁸

We have complex rules defining what the term “related to the ability to work” means. Even if there has been medical improvement related to the ability to work, the ALJ will find that an adult’s disability continues if the adult has an impairment(s)—including any new impairment(s) that was not present at the time of the CPD— or a combination of impairments that meets the basic definition of disability; that is, if he or she is unable to engage in SGA. Similarly, an ALJ will find that a child whose impairment(s) meets or medically equals a listing or functionally equals the listings (*i.e.*, that results in “marked and severe functional limitations”) is still disabled even if there has been medical improvement in the CPD impairment(s). Suffice it to say that an ALJ may ask for your opinions about issues such as the following:

⁴⁶ There are certain specific and very limited exceptions to the requirement for showing medical improvement. See 20 CFR [404.1594\(d\)](#) and (e), [416.994\(b\)\(3\)](#) and (4), and [416.994a\(e\)](#) and (f).

⁴⁷ There is no corresponding provision for children under Title XVI.

⁴⁸ For further guidance on medical improvement in cases involving children, see [SSR 05-03p](#).

- What the signs, symptoms, and laboratory findings associated with a claimant’s impairments were *at the time of the CPD*.
- What the signs, symptoms, and laboratory findings associated with the CPD impairments were (if any) *at the time the DDS said that disability ended or at a later date*.
- Whether the individual’s CPD impairment(s) met or equaled a listing at the time the DDS said that disability ended or at a later date.⁴⁹
- Whether all of the individual’s impairments, including any new impairment(s) in addition to the CPD impairment(s), met or medically equaled a listing at the time the DDS said that disability ended or at a later date.
- The individual’s functional limitations at the time the DDS said that disability ended or at a later date based only on the CPD impairments or based on all of the individual’s impairments.

As you can see, these questions are very similar to the questions you are asked to give opinions about in initial adult and child disability claims. However, in these cases, the ALJ will ask you to give your opinions only about specific impairments the claimant has or had in the CPD, and will specify dates for which you should provide your opinions. You should cite to specific evidence from the record to support your testimony.

Age-18 Redeterminations

Title XVI of the Act requires that we “redetermine” the eligibility of individuals who were eligible for a Title XVI (SSI) payment as a child when they reach age 18. The Act specifies that we must use the rules we use when we determine initial disability in adults, and not the medical improvement review standard we use in CDRs. Under our regulations, for age-18 redeterminations, we use the adult sequential evaluation process to evaluate disability in initial adult claims, except that we do not use step 1 (Is the claimant engaging in SGA?). 20 CFR [416.987](#). In these cases, you will not need to distinguish CPD impairments from all current impairments, as in CDRs. The ALJ will ask you the same kinds of questions that he or she would ask in any initial adult claim for disability benefits.

⁴⁹ In some cases, the ALJ may ask you for an opinion about whether the impairment(s) met or equaled a listing that we no longer have either because we have removed or revised it. If that is the case, the ALJ will provide you with the necessary information you need to answer the question.

Interrogatories

As we have already noted, we may ask you to respond in writing to specific written questions referred to as *interrogatories*. You may receive interrogatories from the ALJ, but you may also receive interrogatories from hearing office staff before a case is assigned to an ALJ for a hearing. If you receive interrogatories before a hearing, the ALJ may or may not ask you to also appear and testify at the hearing.

An ALJ may also send you interrogatories that were posed by the claimant or the claimant's representative. The ALJ must approve any interrogatories proposed by a claimant or representative. You should never answer interrogatories submitted directly to you from the claimant or his or her representative, and you should send your responses to interrogatories only to the ALJ. The ALJ and his or her staff will ensure that the claimant and his or her representative receive a copy.

Usually, the interrogatories will be in the form of a questionnaire. You may type or legibly write your responses directly on the questionnaire if space permits. If you need more space to answer a question, attach separate sheets of paper with your responses. You should answer all questions completely. It is especially important that you explain and support your responses with references to specific medical findings and other evidence you received from the hearing office. Identify the reports in which they are contained. All correspondence between you and the ALJ will become part of the official case record.

If you have a question about any of the interrogatories, you should request clarification from the ALJ (or the Hearing Office Chief Administrative Law Judge if the case is not yet assigned to a particular ALJ) in writing.⁵⁰ If you cannot answer a particular question or cannot answer it completely, because of conflicts in the evidence or because the evidence is incomplete, you should respond by explaining why you cannot answer the question. If possible, you should also provide an opinion and recommendation to the ALJ about what evidence he or she could obtain to resolve the conflict or complete the record.

If the interrogatories relate to new medical evidence the ALJ received after you testified or responded to other interrogatories, you should state whether the new evidence changes any of your prior responses and why.

⁵⁰ Any requests for clarification should be in writing, not over the phone or through other means.

Note that in all cases, the ALJ will submit the questions and your responses for review to the claimant's representative (if the claimant has a representative) with a copy to the claimant (or just to the claimant if unrepresented). The claimant has the right to request a supplemental hearing or to produce other information, to rebut any of your responses.

Other Medical Considerations

Mental Impairments in Adults

In addition to extensive information in the introductory text of the mental disorders “body system” in the Listings (section 12.00, Mental Disorders), the agency has separate regulations specifically for the evaluation of mental disorders in adults. 20 CFR [404.1520a](#) and [416.920a](#). These regulations require the ALJ to specify the symptoms, signs, and laboratory findings that establish the existence of a medically determinable mental impairment(s).

If the claimant has a mental impairment(s), the ALJ must rate the functional limitations in the same four broad functional areas that appear in the “paragraph B” criteria of the adult mental disorders listings: 1. Understand, remember, or apply information; 2. Interact with others; 3. Concentrate, persist, or maintain pace; and 4. Adapt or manage oneself.⁵¹ This four-part rating is the *psychiatric review technique* (technique); ALJs apply the technique to make the threshold determination of severity with regard to a mental impairment. The technique requires the ALJ to rate the four areas of mental functioning on a five-point scale: none, mild, moderate, marked, and extreme.⁵² You should be familiar with the four functional areas and the five-point rating scale. See section [12.00](#)(E) and (F) for a full description of these concepts.

After the ALJ rates the degree of limitation in each domain, he or she concludes whether the claimant has a “severe” impairment (step two of the adult sequential evaluation process).

Then, the ALJ determines whether the impairment(s) meets or medically equals one of the mental disorders [listings](#) (step three of the adult sequential evaluation process). There are 11 categories of disorders within the mental disorders listings, ranging from neurocognitive disorders (listing 12.02) to trauma- and stressor-related disorders (listing 12.15). Each mental disorders listing (except 12.05) has an “A” section (or “paragraph A” criteria) and a “B” section (or “paragraph B” criteria, described above). Some listings also have “paragraph C” criteria (listings 12.02, 12.03, 12.04, 12.06, and 12.15 only); the paragraph C criteria may be applicable if the claimant’s impairment does not satisfy the paragraph B criteria. To meet a listing, the claimant’s impairment must satisfy the “paragraph A” and “paragraph B”

⁵¹ Please note that the revised mental listings took effect on January 17, 2017. Click [here](#) to view the revised listings.

⁵² The technique also requires the ALJ to consider limitations from combinations of mental impairments throughout the application of the technique.

criteria, or where applicable, the “paragraph A” and “paragraph C” criteria, stated in the listing.⁵³

Listing 12.05, Intellectual Disorder, has two paragraphs, A and B. Each paragraph contains three subparagraphs. To meet listing 12.05A or 12.05B, the claimant’s impairment must satisfy the requirements in all three subparagraphs. The second subparagraph (B2) in listing 12.05B includes the same “paragraph B” criteria as in the other mental disorders listings.

After applying any relevant listings, if necessary, the ALJ determines whether to assess an RFC and continue the sequential evaluation process.

When you testify or give written evidence in a case involving an alleged mental disorder, you should be prepared to testify about: the signs, symptoms, and laboratory findings in the case record regarding the claimant’s alleged mental disorder(s); your opinion about the claimant’s functional limitations in the four broad areas of functioning using the rating terms in 20 CFR [404.1520a](#) and [416.920a](#) and in more specific work-related terms in connection with an RFC assessment; and your opinion about whether any mental disorder(s) “meets” or “medically equals” a listing. Importantly, you must cite to specific evidence in the case record to support your testimony.

Symptom Evaluation (20 CFR 404.1529 and 416.929)

A claimant’s symptoms—such as pain, fatigue, weakness, and nervousness—are often significant to the ALJ’s determination of whether a claimant is disabled. Agency policy provides that symptoms can sometimes suggest a greater severity of impairment than is demonstrated by objective medical findings alone. An ALJ evaluates the objective medical evidence (medical signs and laboratory findings), the claimant’s testimony, statements from medical sources, and other relevant evidence. Then, the ALJ makes a finding regarding the extent to which the claimant’s symptoms limit his or her ability to perform work-related activities for an adult (or, for a child with a Title XVI disability claim, the ALJ makes a finding regarding the child’s ability to function independently, appropriately, and effectively in an age-appropriate manner). In making such a finding, the ALJ considers whether the claimant’s symptoms are consistent with the evidence of record.⁵⁴

⁵³ We recommend reading section [12.00](#), and listings 12.02-12.15, to become familiar with how we assess mental disorders listings. Note that listing 12.05 (intellectual disorders) is unique, as it requires the claimant to satisfy either paragraph A or paragraph B.

⁵⁴ SSR [16-3p](#).

The ALJ may ask for your assistance in comparing a claimant's symptoms to the other evidence in the record. If the ALJ asks you to consider the effects of a claimant's symptoms, you should consider those symptoms, including symptoms from any treatment side-effects, in terms of any additional physical or mental limitations or restrictions they may impose beyond those clearly demonstrated by the objective physical or mental manifestations of the claimant's impairment(s).

Our regulations and other rules require the ALJ to consider many factors that will help him or her assess the effects of a claimant's symptoms. They include, but are not limited to: the claimant's daily activities; the location, duration, frequency, and intensity of the symptom(s); precipitating and aggravating factors; the type, dosage, effectiveness, and adverse side effects of any medication; treatment, other than medication, the claimant uses or has used for relief of the symptom(s); other measures the claimant uses or has used to relieve the symptom(s) (e.g., lying flat or sleeping on a board for back pain); and any other factors concerning the claimant's functional limitations and restrictions. 20 CFR [404.1529](#) and [416.929](#); SSR [16-3p](#).

Onset of Disability

The onset date of disability is generally the first day a claimant is disabled as defined in the Act.⁵⁵ Factors relevant to the determination of disability onset include the individual's allegations, work history, medical evidence, and any other relevant information in the case record. The ALJ may ask for your opinion about when a claimant's impairment(s) first reached a specified level of severity or caused functional limitations that the ALJ will specify. Note that in some cases, the ALJ may ask for your expert opinion about these issues for periods that precede the earliest medical evidence in the record. For example, an ALJ may ask you to give an opinion about a reasonable onset date before a disabling cancer was diagnosed, even before the claimant first sought medical help.

Duration of Disability

Duration refers to that period of time during which an individual is continuously disabled. The Act provides that, in order to be considered

⁵⁵ However, a claimant cannot be eligible for Title XVI (SSI) payments until the month after the month of application, so the ALJ will often choose the application date as the onset date, if the claimant is disabled. Nevertheless, you should be prepared to provide testimony about all of the medical records, even if they predate the application, unless the ALJ asks you to limit your testimony to the date of the application or another specific date.

disabled, most impairments must have lasted or be expected to last for a continuous period of not less than 12 months or be expected to result in death.⁵⁶ The claimant need not be unable to work every single day of the 12-month period. Social Security policy recognizes that many impairments are subject to exacerbation and remission, and temporary remissions do not usually prevent claimants from meeting the "continuous period" criteria. SSA rules sometimes speak of evaluating a claimant's impairment "longitudinally;" that is, to form a picture of the person's functioning over time.

Two or more unrelated severe impairments cannot be combined consecutively to meet the duration test. For example, if an individual fractured an upper extremity in May 2005 that healed and caused no functional limitations as of November 2005, and the same individual fractured a lower extremity in October 2005 which healed and caused no further limitations as of June 2006, these impairments could not be combined to meet the 12-month test. This individual could not be found disabled even if each of these impairments was sufficiently severe to preclude work activities for each period at issue.

Also, if an individual has multiple impairments, but one or more of those impairments improves or is expected to improve within 12 months, so that the combined effect of the remaining impairments is no longer severe, the duration test is not met.

Failure to Follow Prescribed Treatment

In evaluating the claimant's symptoms, the ALJ will consider the claimant's attempts to seek medical treatment and to follow treatment once it is prescribed. The treatment must be prescribed by the claimant's own treating source;⁵⁷ it cannot simply be a recommendation, nor can you, as the medical expert, recommend or prescribe it. An ALJ *may*, however, ask you for your opinion about the expected effect or result of treatment that a claimant's treating source has prescribed. However, if the frequency or extent of treatment sought is not comparable with the degree of subjective complaints, or if the claimant fails, without good reason, to follow prescribed treatment that might improve symptoms, we may find the alleged intensity

⁵⁶ The exception is for blindness under Title XVI. The Act does not provide a duration requirement for such cases.

⁵⁷ The term "treating source" will be used only for claims filed before March 27, 2017. For claims filed on or after March 27, 2017, the term "medical source" will be used. See 20 CFR [404.1520c](#), [404.1527](#), [416.920c](#), and [416.927](#); [82 FR 5844](#) and [82 FR 15132](#) (01/18/17; 03/27/17).

and persistence of an individual's symptoms are inconsistent with the overall evidence of record.

The ALJ will not find the claimant's symptoms inconsistent with the evidence without considering possible reasons he or she did not comply with treatment or seek treatment consistent with the degree of his or her complaints. The ALJ may also ask you to provide information that will help him or her make a finding about whether the claimant had an acceptable reason for failing to seek or to follow prescribed treatment. Examples of such reasons include:

- Acceptance of prescribed treatment would be contrary to the teachings and tenets of the claimant's or beneficiary's religion.
- Cataract extraction for one eye is prescribed, but the loss of visual efficiency in the other eye is severe and cannot be corrected through treatment;
- The individual is unable to afford prescribed treatment which he or she is willing to accept, but for which free community resources are unavailable.
- Any duly licensed treating medical source who has treated the claimant or beneficiary advises against the treatment prescribed for the currently disabling condition.
- Surgery was previously performed with unsuccessful results and the additional major surgery is again being prescribed for the same impairment;
- The treatment is very risky for the claimant because of its magnitude, unusual nature, or other reason (e.g., organ transplant, open heart surgery); or
- The treatment involves amputation of an extremity.

Depending on the facts of the case, other reasons for failing to pursue treatment may be relevant and acceptable. See SSR [16-3p](#) for further examples and explanation.

List of References

Social Security's regulations are compiled in Title 20 of the *Code of Federal Regulations*. Social Security Rulings (SSR) are published by the Commissioner to explain and give detail to principles set out in the Social Security Act and regulations. The following is a list of regulation sections and SSRs that you should be familiar with. Acquaintance with the regulations and SSRs is essential to a complete understanding of the role of medical evidence in Social Security disability adjudication. However, we do not intend this list to be a complete reference to all Social Security policy related to disability benefits. The ALJ will tell you if there are other policy statements with which you must be familiar in a given case.

You can find the full text of the Act, regulations, SSRs, and other instructions at <https://www.socialsecurity.gov/regulations/>.

- To go directly to the regulations that start with the number "404" (Part 404), go to https://www.socialsecurity.gov/OP_Home/C.F.R.20/404/404-0000.htm.
- The table of contents for the Part 416 regulations is at https://www.socialsecurity.gov/OP_Home/C.F.R.20/416/416-0000.htm.
- To find the SSRs by year, go to https://www.socialsecurity.gov/OP_Home/rulings/rulfind1.html. The first number in an SSR citation is the year of publication. For example, we published SSR 16-3p in 2016.

The Listing of Impairments is found at 20 CFR Part 404, Subpart P, Appendix 1:

<https://www.socialsecurity.gov/disability/professionals/bluebook/index.htm>.

Note: SSA keeps the online "[Blue Book](#)" (*Disability Evaluation Under Social Security*) up to date, while we update the listings in the regulations link above only once a year. We prefer that you refer to the online "Blue Book" to ensure that you are considering the most recent version of the listings.

Regulation Sections

20 CFR 404.1520, *Evaluation of disability in general, and 416.920, Evaluation of disability of adults, in general*

20 CFR 416.924, *How we determine disability for children*

20 CFR 416.924a, *Considerations in determining disability for children*

20 CFR 416.924b, *Age as a factor of evaluation in the sequential evaluation process for children*

20 CFR 404.1525, *Listing of Impairments in appendix 1, and 416.925, Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter*

20 CFR 404.1526, *Medical equivalence, and 416.926, Medical equivalence for adults and children*

20 CFR 416.926a, *Functional equivalence for children*

20 CFR 404.1529 and 416.929, *How we evaluate symptoms, including pain*

20 CFR 404.1545 and 416.945, *Your residual functional capacity*

Social Security Rulings

SSR 82-57, Titles II and XVI: Loss of Speech

SSR 82-59, Failure to Follow Prescribed Treatment

SSR 83-20, Titles II and XVI: Onset of Disability

SSR 86-8, Titles II and XVI: The Sequential Evaluation Process

SSR 96-8p, Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims

SSR 98-1p, Title XVI: Determining Medical Equivalence in Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech

SSR 02-1p, Titles II and XVI: Evaluation of Obesity

SSR 03-1p, Titles II and XVI: Development and Evaluation of Disability Claims Involving Postpolio Sequelae

SSR 03-2p, Titles II & XVI: Evaluating Cases Involving Reflex Sympathetic Dystrophy Syndrome/Complex Regional Pain Syndrome

SSR 03-3p, Titles II and XVI: Evaluation of Disability and Blindness in Initial Claims for Individuals Aged 65 or Older

SSR 06-01p, Titles II and XVI: Evaluating Cases Involving Tremolite Asbestos-Related Impairments

SSR 09-1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule — The “Whole Child” Approach

SSR 09-2p, Title XVI: Determining Childhood Disability — Documenting a Child’s Impairment-Related Limitations

SSR 09-3p, Title XVI: Determining Childhood Disability — The Functional Equivalence Domain of “Acquiring and Using Information”

SSR 09-4p, Title XVI: Determining Childhood Disability — The Functional Equivalence Domain of “Attending and Completing Tasks”

SSR 09-5p, Title XVI: Determining Childhood Disability — The Functional Equivalence Domain of “Interacting and Relating with Others”

SSR 09-6p, Title XVI: Determining Childhood Disability — The Functional Equivalence Domain of “Moving About and Manipulating Objects”

SSR 09-7p, Title XVI: Determining Childhood Disability — The Functional Equivalence Domain of “Caring for Yourself”

SSR 09-8p, Title XVI: Determining Childhood Disability — The Functional Equivalence Domain of “Health and Physical Well-Being”

SSR 11-2p, Titles II and XVI: Documenting and Evaluating Disability in Young Adults

SSR 12-2p, Titles II and XVI: Evaluation of Fibromyalgia

SSR 13-2p, Titles II and XVI: Evaluating Cases Involving Drug Addiction and Alcoholism

SSR 14-1p, Titles II and XVI: Evaluating Cases Involving Chronic Fatigue Syndrome (CFS)

SSR 14-2p, Titles II and XVI: Evaluating Diabetes Mellitus

SSR 14-3p, Titles II and XVI: Evaluating Endocrine Disorders Other Than Diabetes Mellitus

SSR 15-1p, Titles II and XVI: Evaluating Cases Involving Interstitial Cystitis (IC)

SSR 16-3p, Titles II and XVI: Evaluation of Symptoms in Disability Claims (superseding SSR 96-7p)

SSR 16-4p, Titles II and XVI: Using Genetic Test Results to Evaluate Disability

SSR 17-2p, Titles II and XVI: Evidence Needed by Adjudicators at the Hearings and Appeals Council Levels of the Administrative Review Process to Make Findings about Medical Equivalence