MEDICAL EXPERT HANDBOOK
Social Security Administration
Office of Disability Adjudication and Review
Office of the Chief Administrative Law Judge

Preface

Thank you for becoming a medical expert for our Office of Disability Adjudication and Review (ODAR). 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:

Social Security Administration
Office of Disability Adjudication and Review
Office of the Chief Administrative Law Judge
Table of Contents

In General-Disability Overview, Medical Experts, and the Social Security Appeals Process 1

What are Social Security’s Disability Programs? 1

Where Do You Fit In? 1

What is an “ME”? 3

What is an ALJ? 3

What is “Disability” for Social Security Programs? 3

What Happens at the ALJ Hearing? 5

What is the Appeals Council? 6

What are Federal Court Appeals? 7

Role of the ME 8
• Responsibilities of the ME 8
• Conduct of the ME 9
• Pre-Hearing Preparation 9
• Protecting Personally Identifiable Information (PII) 10

Determining Disability 12
• Detailed Definitions of Disability 12

Determining Initial Disability for All Title II and Adult
Title XVI Cases 14
• The Sequential Evaluation Process 14
• Step 1 15
• Step 2 15
• Step 3 17
• Residual Functional Capacity (RFC) 19
• Step 4 21
• Step 5 21

Determining Initial Disability under Title XVI for Individuals
under Age 18 (SSI Childhood Cases) 23
Determining Continuing Disability
- CDRs and Medical Improvement 27
- Age -18 Redeterminations 28

Interrogatories 30

Other Medical Considerations
- Mental Impairments in Adults 32
- Evaluation of Pain and Other Symptoms 34
- Onset of Disability 34
- Duration of Disability 35
- Failure to Follow Prescribed Treatment 36

List of References 37
In General-Disability Overview, Medical Experts, and the Social Security Appeals Process

What are Social Security’s Disability Programs?

The Social Security Administration (SSA) administers several programs that pay disability benefits to individuals. Disability benefits may be paid to people who work in “covered” employment or self-employment and who pay sufficient Social Security taxes\(^1\) 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 Social Security Act\(^2\) (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. 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 (MEs) to provide evidence at hearings before an administrative law judge (ALJ). 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.

---
\(^1\) Federal Insurance Contributions Act (FICA) or Self-Employment Contributions Act (SECA) taxes.
\(^2\) The Social Security Act, 42 U.S.C. 301 et seq., is the federal law governing Social Security Benefits.
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” (CEs), when they need them. In general, the determination at the DDS is made by a team consisting of a medical professional (called a medical consultant or psychological consultant) and a lay disability examiner. While DDS adjudicators routinely contact claimants to collect information, they usually do not meet with claimants. The DDS disability determination is based on a weighing of documentary 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 who are otherwise dissatisfied with their determinations 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

---

3 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” 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.

4 For example, some people are found disabled at the DDS level, but not for the entire period they claimed.
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 26.

**What is an “ME”?**

An ME is a physician, psychologist, speech-language pathologist, and certain other types of medical professionals who provides impartial expert opinion evidence that an ALJ considers when making a decision about disability. As an ME, you will usually testify in person at a hearing, although you may be asked to testify by video teleconferencing (VTC) technology or telephone, and sometimes you may provide opinions in writing by answering written questions called *interrogatories* (which we explain on page 30).

**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 (SSI). There is a separate definition for children (individuals who have not attained age 18) under the 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 activity\(^5\) 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.

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

\(^5\) The concept of substantial gainful activity is explained in more detail on page 15.
[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.\textsuperscript{6}

The 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 SSI program.

The definition of disability for children under SSI is:

\begin{quote}
\textbf{[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.\textsuperscript{7}
\end{quote}

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

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 12.

\textsuperscript{6} 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 vocational expert.

\textsuperscript{7} Children can also qualify for SSI based on “blindness.”
What Happens at the ALJ Hearing?\textsuperscript{8}

In the vast majority of cases at the hearing level, ALJs hold hearings at which claimants, and sometimes other people,\textsuperscript{9} appear and testify. This 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 opinions in response to interrogatories.

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\textsuperscript{10}. The ALJ will also ask the claimant and his or her representative, if any, whether they object to your testifying.

In many cases, all of the participants in the hearing will be present in the same room for the hearing. However, increasingly, we have been using VTC technology to improve our capacity to hold timely hearings. You may be asked to testify by VTC or telephone. Regardless of how the testimony is

---

\textsuperscript{8} See page 9 of this handbook for additional information about prehearing review and about preliminary questions the ALJ will ask you to establish your expertise and impartiality.

\textsuperscript{9} Such as family members and medical and vocational expert witnesses.

\textsuperscript{10} The program requirements you should understand are listed on page 8.
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 hearing will be recorded.

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 written questions called *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 throughout the country. The Appeals Council’s headquarters is in Falls Church, Virginia; it also has offices in 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* (returns) the case to the ALJ for additional action, including possibly a new hearing.

---

11 Interrogatories are explained on page 30.
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 United States District Court. The district court may uphold, 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 (a “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:

- 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”).\(^{12}\)

- SSA’s definitions of “meeting” and “medically equaling” specific listings.

- The concept of *residual functional capacity* (RFC) for all cases except 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 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.

You will provide evidence by answering questions posed by the ALJ, the claimant, and the claimant’s representative. You *may* 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.\(^{13}\) You *may also* answer questions which ask for your medical opinion about the nature and severity of a claimant’s impairment(s), including symptoms,

\(^{12}\) 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.

\(^{13}\) We explain the concepts of “meeting” and medically equaling a listing later in this handbook.
You will rarely have the opportunity to question the claimant directly during the hearing. 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; the ALJ may ask the question himself or herself or allow you to ask the question. 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.

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 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), treatment and side effects, and the evidence about the claimant’s functional limitations, you can expect to get 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 at an earlier time or that start at a later time. The ALJ will advise you of the period under consideration.

**Protecting Personally Identifiable Information (PII)**

The Social Security Administration defines PII as any information which 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 which 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 agency 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 to immediately report to SSA when you suspect PII is compromised, could adversely affect your standing and may result in reduced requests for your services. To maintain good standing with SSA, follow these instructions to reduce the risk of PII loss, theft or inadvertent disclosure:

- Ensure your employees are fully aware of these procedures and the importance of protecting PII.

---

15 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.
• 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.

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 contribute to a determination of reduced requests for your services.
**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 benefits. Less often, you may testify at hearings concerning the other kinds of disability cases described below.

**Detailed Definitions of Disability**

The Social Security 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. 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 which 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 as well.

“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 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.

---

16 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 3 of this handbook.
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.” The Act also states that the child must not be engaging in SGA. An impairment(s) causes marked and severe functional limitations if it meets or medically equals a specific listing, or if it functionally equals\(^\text{17}\) the listings. We have separate medical listings for 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 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.\(^\text{18}\) 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.

\(^{17}\) The policy of functional equivalence applies only to children (individuals under age 18) and only in the SSI program.

\(^{18}\) Although the Act refers to “drug addiction” and “alcoholism,” SSA’s interpret 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.*
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 or still 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 SSI 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 416.920.19

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,20 ALJs generally do not make their decisions at the hearing. ALJs generally issue a written decision some time 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.

19 “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.

20 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?\(^{21}\)

*Substantial gainful activity* (SGA) is work 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 it is “severe.”\(^{22}\) As we have already noted, the Act requires that the claimant show the existence of an impairment by medically acceptable clinical and laboratory diagnostic techniques, which we often refer to as “objective” medical evidence.

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. 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.\(^{23}\)

\(^{21}\) 20 CFR 404.1574, 404.1575, 416.974, and 416.975 provide evaluation guides for determining whether work is SGA.

\(^{22}\) There is no requirement to establish a medically determinable impairment that results in blindness under Title XVI.

\(^{23}\) 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.
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. SSR 85-28. 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.” Under agency rules, “medically determinable impairments” must be established by symptoms, signs, and laboratory findings, although in practice SSA may find that there is a medically determinable impairment based only on signs or laboratory findings. Note that it is not necessary to establish a specific diagnosis to show the existence of a medically determinable impairment. There need only be objective medical evidence demonstrating some medical condition to cross this threshold in the rules.

**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. (In Title XVI child cases, we will accept as a statement of a symptom(s) the description given by the person who is most familiar with the child, such as a parent, other relative, or guardian, if the child is unable to adequately describe his or her symptom(s).)

**Signs** are anatomical, physiological, or psychological abnormalities which can be observed apart from the claimant’s 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 anatomical, physiological, or psychological phenomena which can be shown by the use of medically acceptable laboratory diagnostic techniques. Some of these diagnostic techniques include chemical tests, electrophysiological studies (electrocardiogram, electroencephalogram, etc.) 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

---

24 “SSR” stands for “Social Security Ruling,” a type of sub-regulatory rule that ALJs and our other adjudicators must follow. See the List of References at the end of this handbook for the title of this SSR and a list of important SSRs that you may need to consult.
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 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 set out in Appendix 1, Subpart P of Part 404 of our regulations (the listings) 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 prevent an adult from doing “any gainful activity” 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. 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. 20 CFR 404.1525 and 416.925.

The Listing of Impairments is 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

---

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

26 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 consider the vocational factors of previous work experience, age, and education that are considered at the last step of the sequential evaluation process.

27 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.

28 Unrelated severe impairments cannot be combined to meet the 12-month duration requirement. 20 CFR 404.1522 and 416.922.
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.

Each body system section of 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. Regardless of whether the medical findings needed to support an impairment are provided in the introductory text or elsewhere in the listing, the existence of an impairment covered by a listing must be established by medical evidence consisting of signs, symptoms, and laboratory findings.

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 additional requirements in the introductory text are satisfied. A medical diagnosis alone is insufficient to meet a listing.29

Agency rules also provide for the possibility of “medical equivalence” with a specific listing because the Listing of Impairments does 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 meets or medically equals 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.

29 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.
You will frequently be asked whether you think a claimant’s impairment(s) meets or medically equals a listing. You must be prepared to identify listings that are appropriate to the claimant’s impairment(s); and either to identify the evidence in the case record that shows that the impairment(s) meets or medically equals a specific listing, or to explain why it does not.

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.

**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).

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.”

You will frequently be asked your opinion about claimants’ functional abilities, limitations, and restrictions. 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. 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

---

30 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.

31 Other relevant evidence can include the claimant’s own statements and the statements of other people who know the claimant.
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:

- First, 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.32

- Second, 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,33 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.

32 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.

33 Note, however, that SSA may consider obesity to be a medically determinable impairment. See, e.g., SSR 02-1p, cited in the List of References at the end of this handbook.
**STEP 4:** Can the claimant do any past relevant work?

After assessing 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.

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, which 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 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, he or she is not disabled. If the claimant cannot, 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 (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 SSI is different from the process for adults. The standard of disability for children who seek SSI 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 SSI childhood sequential evaluation process are:

**Step 1:** Is the child engaging in substantial gainful activity?

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 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 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 Listing of Impairments; 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 SSI child claimants are described in more detail in 20 CFR 416.924a and 416.926a of the regulations and in SSRs 09-1p through 09-8p.\textsuperscript{34}

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 groups\textsuperscript{35} in 20 CFR 416.926a(g) through (l) and SSRs 09-3p through 09-8p. If you testify in SSI childhood disability claims, you must be familiar with these rules and guidance; however, you should also provide your own pediatric expertise.

\textbf{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 functional equivalence.\textsuperscript{36} 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 SSI benefits does not have the same meaning as the separate terms "marked" and "severe" we use in other rules. 20 CFR 416.902.

\textsuperscript{34} See the List of References at the end of this handbook.
\textsuperscript{35} 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.
\textsuperscript{36} 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 claims involving 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. We refer to these cases as continuing disability reviews (CDRs) or “cessation” cases.

- Title XVI also requires that we redetermine the disabilities of individuals who qualified for SSI 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 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. The primary difference is that there generally must be evidence showing medical improvement in the individual’s condition from the more recent of the date he or she was first found disabled or the last time we found that the disability continued. 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.

37 We review cases at frequencies ranging from as little as 6 months 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.
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:

- The impairment(s) upon which we last found him or her to be disabled or still disabled has medically improved, 38
- The medical improvement is “related to the ability to work” in the case of adults, 39 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 the signs, symptoms, and laboratory findings. 20 CFR 404.1594(c)(2), 416.994(b)(2), and 416.994a(c). 40

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

38 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).
39 There is no corresponding provision for children under SSI.
40 For further guidance on medical improvement in cases involving children, see also SSR 05-03p.
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:

- 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.  

- 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, and will specify dates for which you should provide your opinions.

**Age -18 Redeterminations**

Title XVI of the Act requires that we “redetermine” the eligibility of individuals who were eligible for an 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, 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

41 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.
the same kinds of questions that he or she would ask in any initial adult claim for disability benefits.
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. 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.

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: activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation. This psychiatric review technique (technique) is applied to make the threshold determination of severity with regard to a mental impairment. While the listings provide measures to determine whether an impairment imposes listing-level limitation in each domain, the technique requires the ALJ to rate the domains on a multi-point scale.43 The technique provides a five-point scale for the first three domains: none, mild, moderate, marked, and extreme. For the fourth domain (episodes of decompensation), the scale is: none, one or two, three, and four or more.

After the ALJ rates the degree of limitation in each domain, he or she determines whether the claimant has a “severe” impairment (step two of the adult sequential evaluation process), whether the impairment(s) meets or medically equals one of the mental disorders listings (step three of the adult sequential evaluation process), and if necessary, whether to assess RFC and go on in the sequential evaluation process.

There are three other provisions of these regulations you should know:

42 “Marked” limitation for meeting the requirements of a mental disorders listing in the first three paragraph B criteria. The fourth paragraph B criterion is rated by the number of episodes of decompensation, and is met with three such episodes. See section 12.00C in the introductory text of the adult mental disorders listings for a description of the paragraph B criteria and definitions of the terms we use to rate whether a mental disorder meets one of the listings.

43 With one exception (listing 12.05C), the adult mental disorders listings describe only individual mental disorders, not combinations of such disorders. Combinations of mental disorders can medically equal mental disorders listings. The technique also requires the ALJ to consider limitations from combinations of mental impairments throughout the application of the technique.
First, the regulations specify that we use the criteria in sections 12.00C through 12.00H when we rate severity under the scales we describe above. This includes using the same definition of the term “marked” as we use in section 12.00C.

Second, as in the adult mental disorders listings, the ALJ must consider the extent to which a mental impairment(s) interferes with the claimant’s ability to function “independently, appropriately, effectively, and on a sustained basis” and provides guidance about some of the factors the ALJ must consider in making this determination.

Third, the regulations specify that the last point on each of the two rating scales described above “represents a degree of limitation that is incompatible with the ability to do any gainful activity.” As you learned in the section explaining step three of the adult sequential evaluation process (page 17), “inability to do any gainful activity” is the standard of listing-level severity for adults. This means that an adult who has an “extreme” limitation in only one of the first three broad areas of functioning or “four or more episodes of decompensation” as defined in our rules, has an impairment(s) that medically equals a mental disorders listing.

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) “meet” or “medically equal” a listing. If you testify in a case involving intellectual disabilities (mental retardation), you must also be familiar with instructions we have in an operating manual called the Program Operations Manual System (POMS). The POMS includes guidance for determining whether “mental retardation” medically equals listing 12.05C. See POMS DI 24515.056D Evaluation of Specific Issues — Mental Disorders — Determining Medical Equivalence, available at https://secure.ssa.gov/apps10/poms.nsf/lnx/0424515056!opendocument.

---

44 20 CFR 404.1520a(c)(4).  
45 The entire POMs is available at http://policy.ssa.gov/poms.nsf/aboutpoms
Evaluation of Pain and Other Symptoms (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 both the objective medical evidence (medical signs and laboratory findings) and the testimony (statements and reports from the claimant, medical sources, and other persons), and makes a finding on the credibility of the claimant's complaints regarding his or symptoms and their functional effects.

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 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 has used to relieve the symptom(s) (e.g., lying flat or sleeping on with 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 96-7p.

Onset of Disability

The onset date of disability is generally the first day a claimant is disabled as defined in the Act.\(^{46}\) Factors relevant to the determination of disability onset

\(^{46}\) However, a claimant cannot be eligible for SSI payments until the month after the month of application, so the ALJ will often choose an onset on the date of the application if the claimant is disabled. Nevertheless, you should be prepared to provide testimony about what the medical records show for the entire period they cover, 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.
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 Social Security Act provides that, in order to be considered 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. 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.

47 The exception is for blindness under Title XVI. The Act does not provide a duration requirement for such cases.
**Failure to Follow Prescribed Treatment**

Social Security regulations and other rules provide that an otherwise disabled claimant who fails, without good reason, to follow prescribed treatment that is clearly expected to restore his or her ability to work (or in the case of a child under Title XVI to improve the impairment(s) to the point of nondisability), cannot be found disabled. The treatment must be prescribed by the claimant’s own treating source; it cannot simply be a recommendation, nor can you 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.

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 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.
List of References

Social Security’s regulations are compiled in Title 20 of the Code of Federal Regulations. Social Security Rulings (SSRs) 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 online at http://www.socialsecurity.gov/regulations/. You can also find a link to these sources and other resources at: http://www.socialsecurity.gov/disability/.

- To go directly to the regulations that start with the number “404” (Part 404), go to this page: http://www.socialsecurity.gov/OP_Home/cfr20/404/404-0000.htm.
- The table of contents for the Part 416 regulations is on this page: http://www.socialsecurity.gov/OP_Home/cfr20/416/416-0000.htm.
- To find the SSRs by year, go to this page: http://www.socialsecurity.gov/OP_Home/rulings/rulfind1.html. The first number in an SSR citation is the year of publication. For example, SSR 96-7p was published in 1996.


**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 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 404.1528 and 416.928, Symptoms, signs, and laboratory findings

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
Organic Loss of Speech

SSR 82-59
Failure to Follow Prescribed Treatment

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

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

SSR 93-2p
Human Immunodeficiency Virus
SSR 96-3p
Policy Interpretation Ruling Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment is Severe

SSR 96-7p
Policy Interpretation Ruling Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual’s Statements

SSR 96-8p
Policy Interpretation Ruling 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 99-2p
Chronic Fatigue Syndrome

SSR 02-1p
Obesity

SSR 02-2p
Interstitial Cystitis

SSR 03-1p
Postpolio Sequelae

SSR 03-2p
Reflex Sympathetic Dystrophy Syndrome/Complex Regional Pain Syndrome

SSR 03-3p
Policy Interpretation Ruling - 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 06-03p
Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not “Acceptable Medical Sources” in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies

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”