Revised Medical Criteria for Evaluating Musculoskeletal Disorders Final Rules
Questions and Answers

Q1: What are the listings?
A1: The Listing of Impairments (listings) describe medical conditions that are so severe that we presume any person who has one or more medical conditions that satisfy the criteria of a listing is unable to perform any gainful activity regardless of his or her age, education, or work experience and, therefore, is disabled (or, in the case of a child under the Supplemental Security Income (SSI) program, conditions that cause marked and severe functional limitations). The listings represent an expediency in the program to identify claims in which the person is clearly disabled. We do not deny any claim because a person's medical conditions do not satisfy the criteria of a listing. The listings do not contain all possible medical conditions. We divide the listings into Part A listings for adults (age 18 and older) and Part B listings for children (under age 18). Each part lists categories of impairments that we call body systems. There are 14 body systems in Part A and 15 body systems in Part B. Part B listings have a body system for low birth weight and failure to thrive, which are not in Part A.

Q2: When did the Social Security Administration (SSA) last update the musculoskeletal disorders listings?
A2: Prior to December 2020, we last published final rules making comprehensive changes to the musculoskeletal disorders listings for adults and children on November 19, 2001. These rules were effective on February 19, 2002.[1]

Q3: When will these final rules go into effect?
A3: We published the revised final rules on December 3, 2020.[2] The rules are effective on April 2, 2021. Finalizing the musculoskeletal disorders listings represented the last comprehensive update to the listings, better positioning us to make targeted and timely changes in line with medical advancements.

Q4: What percent of decisions do adjudicators make using these revised rules?
A4: We decide claims involving musculoskeletal impairments primarily at step 5 of the sequential evaluation process where we consider a claimant's residual functional capacity (RFC), age, education, and work experience. Specifically, we make 90 percent of allowances due to a musculoskeletal impairment using the medical-vocational rules at step 5 of the sequential evaluation process, which have not changed. The remaining 10 percent of the people who apply for disability benefits and are found disabled after an initial review due to a musculoskeletal impairment meet (or medically equal) a musculoskeletal disorders listing. We do not expect this to change because of these final rules.

Q5: How do these changes affect vulnerable populations?
A5: Our Office of the Chief Actuary's (OCACT) primary conclusion for these rules are that the net effect of the new listings will be very small for both Social Security Disability Insurance (SSDI) and SSI. OCACT estimated that for SSI, there would be a very small net increase in SSI awards of roughly 180 annually. For SSDI, there would be a very small net reduction in disability awards of roughly 260 annually due to these listings.

[1] 66 FR 58009.
[2] 85 FR 78164.

OCACT estimated that implementation of these final rules will result in a net increase in SSI payments of $67 million over fiscal years 2021-2030, and a net reduction in scheduled Old-Age, Survivors, and Disability Insurance (OASDI) benefits of $263 million over the same period, assuming implementation in January 2021. Our Office of Budget, Finance, and Management estimates administrative savings of less than 15 work years and $2 million annually.[3]

It is important to note that while the estimated effects of changes from allowance to denial and from denial to allowance are largely offsetting, the actual net effect for either program, SSDI or SSI, could potentially be either a small cost or a small saving.

Q6: Why did SSA change the functional criteria in the new musculoskeletal disorders listings?
A6: As we explained in the musculoskeletal disorders notice of proposed rulemaking (NPRM)[4] and our response to comments in the final rules, we changed the functional criteria to increase consistency, clarity, and equity in our determinations and decisions across adjudicative levels. Inability to ambulate effectively was not clearly defined and open for interpretation, increasing opportunity for inconsistency and inequity in medical assessments.

Our listings describe medical conditions that are so severe that we presume any person who has one or more medical conditions that satisfy the criteria of a listing is unable to perform any gainful activity regardless of his or her age, education, or work experience and, therefore, is disabled (or, in the case of a child under the SSI program, conditions that cause marked and severe functional limitations). The new functional criteria more clearly describe and represent listing-level severity. They also make it easier for someone to know whether their impairment would satisfy the criteria and what documentation they will need to provide when they apply for benefits.

Q7: How has SSA generally evaluated musculoskeletal disorders under the listings?
A7: We generally evaluate the musculoskeletal disorders using a combination of medical criteria and functional criteria for each type of impairment. The current musculoskeletal listings have two functional criteria: the inability to perform fine and gross movements effectively and the inability to ambulate effectively.

In our prior listings, we defined inability to ambulate effectively as having insufficient lower extremity functioning to permit independent ambulation **without the use of hand-held assistive devices** that limited the functioning of both upper extremities. We also provided examples of the types of things that constitute inability to ambulate effectively, and we used broad terms such as ability to "walk a block" "at a reasonable pace" "over rough or uneven surfaces."

[3] 85 FR 78164, 7874 (2020).
[4] 83 FR 20646 (2018).

Q8: How are the functional criteria evaluated under the new final rules?
A8: The new functional criteria are:

1. A documented medical need for a walker, two canes, or two crutches or a wheeled and seated mobility device (WSMD) (such as a manual wheelchair) involving the use of both hands, or
2. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities[5] involving fine and gross movements, and a documented medical need for a one-handed, hand-held assistive device that requires the use of your other upper extremity or a WSMD involving the use of one hand (such as a powered wheelchair), or
3. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities[5] involving fine and gross movements.

These criteria represent the level of dysfunction for upper and lower extremities that would cause an adult to be unable to work or a child to be unable to perform age-appropriate activities. We consider assistive devices as part of the first and second functional criteria in the musculoskeletal disorders listings.

Q9: The new functional criteria include requirements for people who use WSMDs. What do these changes mean?
A9: We added WSMDs to the listing criteria as a response to public comments, with the intent that they would be considered the same as the other examples provided, such as crutches or walkers that require two hands. We do not expect that these changes will have a significant impact in the outcome of disability applications for people who use wheelchairs or other WSMDs. Not many musculoskeletal disorders alone require use of a WSMD; however, if someone uses a two-handed WSMD, they would satisfy the functional criteria. Further, if someone uses a WSMD requiring only one hand but still needs to use two hands to perform other work-related activity (for example, to balance or to bear weight to transfer from a wheelchair to a seated position), we would find the functional criteria are satisfied. We are providing additional guidance to our adjudicators in this area through sub-regulatory policy.

Q10: How are one-handed WSMDs evaluated?
A10: In response to questions and comments on the need for medical evidence to evaluate one-handed WSMDs, we intend to provide sub-regulatory guidance to help adjudicators understand what type of medical evidence we need to evaluate assistive devices, and when the claim file contains sufficient evidence to evaluate the claim without further development. Specifically, we will provide guidance to:

- **Consider the most restrictive assistance device:**
  - We will clarify that we consider the most restrictive assistive device for which the claimant has a documented medical need when evaluating whether they satisfy the functional criteria.

    Example: A person has a documented medical need for a walker and a motorized (that is, one-handed) WSMD. We will consider the two-handed assistive device

[5] Or, for a child, to perform age-appropriate activities

criteria (criterion 1) because the person has a documented medical need for a two-handed assistive device such as a walker.

- We will also emphasize that while the functional criteria in the musculoskeletal disorders listings require a documented medical need for an assistive device, the listing explicitly state that we do not require that the claimant actually have a prescription for the device or actually use the device.
- We will provide additional guidance to explain that a claimant who has a documented medical need for a one-handed WSMD but needs both hands to complete the activities necessary to function during in a typical work environment satisfies the functional criteria.

  Example: A person who cannot bear weight on his or her lower extremities would need two hands to complete activities necessary to function in a typical work environment, such as toileting or transferring from his or her WSMD.

Q11: What types of evidence can satisfy the requirements for one-handed WSMD device:
A11: The evidence required to support this guidance should already be present in the medical record. Examples of the types of medical evidence we expect to see include:

- Inability to bear weight on the lower extremities;
- Instability;
- Inability to rise from a seated position without assistance or the use of both arms;
- Significant weakness in both legs; or
- Amputation of the lower extremity or extremities at or above the ankle with inability to use a prosthesis.

Corroborative evidence, such as reported use of a two-handed assistive device or limitations in activities of daily living, will likely also be present.

Q12: What are the benefits of this additional guidance?
A12: We intend the additional guidance to reduce both unnecessary burden to the claimant and unnecessary development by the adjudicators by providing flexibility in evaluating the evidence based on what is present in the medical record. This guidance will reduce the time to process the case and make the decision. Further, it provides a clear medical basis for meeting the listing but also prevents potential unintended expanded use of the musculoskeletal disorders listings to allow people who use a one-handed WSMD for other reasons, such as people who use a scooter for some activities, like shopping, as a convenience but who do not routinely require use of a WSMD.

Q13: What were the changes in regards to the close proximity of time of evidence?
A13: We resolve the inconsistent policy application created by the holding in the Fourth Circuit court case, *Radford v. Colvin*, 734 F.3d 288, by explicitly explaining that, when the listing criteria are linked by the word "and," the requirements must be simultaneously present, or present within a "close proximity of time." We further define a "close proximity of time" to mean that all of the relevant criteria in a listing must appear in the medical record within a four-month period.

In recognition to potential barriers to care and inequities, as well as to eliminate any unnecessary evidence development by adjudicators, we are providing additional guidance to adjudicators in this area. Specifically, we explain that when imaging is present in the file that shows findings that are reasonably expected to have been present at the date of the impairment or date of onset, no additional imaging or development is necessary unless there was a potentially corrective surgery or other intervention between the timeframe of the imaging and the other findings.

Because of access to care issues due to the COVID-19 pandemic, we are exploring the possibility of a temporary final rule that could further address the application of the "close proximity of time" criterion.

Q14: What are the other major changes to the listings for musculoskeletal disorders?
A14: We are revising the listings for evaluating musculoskeletal disorders to reflect our adjudicative experience, advances in medical knowledge, and comments we received from the public in response to the NPRM. Specifically, these final rules:

- Differentiate between pathologic fractures and fractures caused by a traumatic event because the medical treatment and recovery expectations for fractures differs, depending on the underlying cause;
- Acknowledge the rapid development of motor function during the infant and toddler stages by adding a child listing for evaluating musculoskeletal disorders of infants and toddlers, from birth to attainment of age 3, with developmental motor delay;
- Revise the content and structure of the current listings to incorporate the new functional criteria into each listing;
- Add specific sections in the introductory text to provide guidance on each listing;
- Emphasize our current policy that a musculoskeletal disorder may meet or medically equal one of these listings regardless of whether the person was prescribed opioid medication, or whether the person was prescribed opioid medication and did not follow this prescribed treatment; and
- Make conforming changes to the relevant criteria in the cardiovascular, endocrine, and immune disorders body systems since those body systems use terminology from the current musculoskeletal disorders listing that we revise in these final rules.

Q15: What happens if a person with a musculoskeletal impairment is not found disabled at step 3 of the sequential evaluation process?
A15: In this situation, we evaluate a claimant who does not meet the criteria at step 3 of the sequential evaluation process under the remaining steps of the sequential evaluation where we consider his or her RFC. This is true for people who use wheelchairs, which may erode the unskilled sedentary occupational base depending on the amount of time they can stand and walk during an 8-hour workday and other RFC restrictions.[6] Additionally, we may find that the person

[6] The full range of sedentary work requires that an individual be able to stand and walk for a total of approximately 2 hours during an 8-hour workday. If an individual can stand and walk for a total of slightly less than 2 hours per 8-hour workday, this, by itself, would not cause the occupational base to be significantly eroded. Conversely, a limitation to standing and walking for a total of only a few minutes during the workday would erode the unskilled sedentary occupational base significantly. For individuals able to stand and walk in between the slightly less than 2 hours and only a few minutes, it may be appropriate to consult a vocational resource. See Social Security Ruling (SSR) 96-9 p: Titles II and XVI: Determining Capability to Do Other Work—Implications of a Residual Functional Capacity for Less than a Full Range of Sedentary Work.

is unable to sustain a 40-hour workweek or equivalent work schedule. In general, we base 90 percent of the claims we allow due to musculoskeletal disorders on the medical-vocational rules at step 5 of the sequential evaluation process and only 10 percent of favorable claims on the musculoskeletal disorders listings. There are no changes to how we evaluate the RFC resulting from the changes to the musculoskeletal disorders listings.

Q16: Will these changes increase the amount of time it takes for the Disability Determination Services (DDS) to decide a claim?
A16: We do not expect these rules to increase processing times. The final rules require medical evidence that should be present in the records for a claimant with severe medical impairments. We are providing sub-regulatory guidance to adjudicators on how to evaluate this medical evidence. This guidance recognizes inequity in access to health care delivery may exist and ensures we do not impose an undue burden on claimants or require unnecessary development by adjudicators.

If we are unable to determine that the musculoskeletal impairment(s) meets or medically equals a listing, in certain situations, we are able to make a fully favorable step 5 determination.[7] The listings describe impairments that preclude the ability to perform ‘‘any gainful activity’’ (or, in the case of a child applying for SSI payments based on disability, to identify impairments that result in marked and severe functional limitations).[8]

Q17: How do the changes to the listings for musculoskeletal disorders affect the listings for other body systems?
A17: We made conforming changes to references to the musculoskeletal disorders listings in the cardiovascular, endocrine, and immune disorders body systems.

- In the cardiovascular disorders body system, we now instruct adjudicators to consider whether a person’s lymphedema may medically equal a musculoskeletal disorders listing, such as 1.18. In the prior listings, we instructed them to consider whether a person’s lymphedema may medically equal a musculoskeletal disorders listing such as 1.02A or 1.03.
- In the endocrine disorders body system, we made a conforming change to comport with the change we made to section 416.926a(m).
- In the immune disorders body system, we made confirming changes to the functional criteria of three immune disorders listings – 14.04, 14.05, and 14.09. These listings directly reference the functional criteria from the musculoskeletal disorders listings.

The changes to the listings for musculoskeletal disorders do not affect the listings for other body systems, such as the neurological disorders body system; thus, we have not changed how we evaluate neurological disorders. This is important to note because neurological disorders more commonly require use of a WSMD than musculoskeletal disorders. Further, if a claimant needs to use a WSMD due to difficulty in breathing, there is no change to how we evaluate this under the respiratory listing.

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[7] If the RFC limitations supported by the case evidence show the claimant cannot do any past relevant work and the claimant’s vocational factors (i.e., age, education, and work experience) direct a fully favorable allowance using the special medical-vocational profiles or the medical-vocational profiles at step 5 of sequential evaluation, we instruct adjudicators to not develop additional evidence to evaluate whether an impairment meets or equals a listing. See POMS DI 24515.020 Curtailing Development of Fully Favorable Claims.
[8] See 20 CFR 404.1525(a) and 416.926(a).

Q18: How will SSA consider obesity under the new rules?
A18: Our policy for evaluating obesity has not changed. We will continue to consider obesity in combination with the musculoskeletal impairment when evaluating a person's medical condition, including whether a person's musculoskeletal impairment meets (or medically equals) a musculoskeletal disorders listing. The new rules, similar to the previous rules, explain the following key points:

- Obesity is often associated with musculoskeletal disorders;
- Obesity increases stress on weight-bearing joints and may contribute to limitation of the range of motion of the skeletal spine and extremities; and
- The combined effects of obesity with a musculoskeletal disorder can be greater than the effects of each of the impairments considered separately.

Q19: Will a lack of opioid treatment adversely affect a person when SSA is determining whether he or she meets or equals a musculoskeletal disorders listing?
A19: No, a lack of opioid treatment will not adversely affect a decision. We added this provision in the final rules to make it clear that a person's musculoskeletal disorder may meet or medically equal one of the musculoskeletal disorders listings regardless of whether the person was prescribed opioid medication, or whether the person was prescribed opioid medication and did not follow this prescribed treatment.

Q20: Will beneficiaries that SSA awarded disability benefits because their musculoskeletal disorder met or equaled a prior musculoskeletal disorders listing lose their benefits when SSA reviews their claim?
A20: We will not terminate any person's disability benefits solely because we have revised these listings. Unless we are otherwise required to do so (for example, by statute), we do not readjudicate previously decided cases when we revise our listings. We must periodically conduct continuing disability reviews (CDR) to determine whether beneficiaries are still disabled but these rules do not change the timeframe for conducting a CDR, nor does it change how we conduct the CDR.

When we conduct medical CDRs, we follow the Medical Improvement Review Standard (MIRS) using an 8-step sequential evaluation process for Title II beneficiaries and Title XVI adults. Under the MIRS, we must show that the person's impairment(s) has medically improved and that any medical improvement is "related to the ability to work." Even where the impairment(s) has medically improved, our regulations provide that the improvement is not "related to the ability to work" if it continues to meet or medically equal the **"same listing section used to make our most recent favorable decision."**[9] This is true even if we have since revised or removed the listing section we used to make the most recent favorable decision. When we find that medical improvement is not related to the ability to work (or, in the case of a person under age 18, the impairment still meets or medically equals the prior listing), we will find that disability continues, unless an exception to medical improvement applies.

[9] 404.1594(c)(3)(i) and 416.994(b)(2)(iii)(A).

** Questions and Answers 21-25 are questions we received during the March 30, 2021 advocates call and the corresponding answers.*

Q21: **What guidance and information has the Social Security Administration given to Administrative Law Judges (ALJ) about scheduling supplemental hearings to ensure ALJs receive evidence that may affect the decision outcome?**
A21: The Office of Hearings Operations is providing written reminders to all ALJs to be cognizant of the potential need for supplemental hearings and the need for additional time to submit evidence in appropriate circumstances.

Q22: **Please explain this language: "*independently initiate, sustain, and completed work-related activities involving fine and gross movements*."**
A22: The functional criterion for limitation in fine and gross movements specifically requires an inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements. See 1.00E4 and 101.00E4.

To do a work-related activity involving fine and gross movements, a claimant must be able to independently initiate and sustain and complete the activity. Limitation in any one of these parts (initiate or sustain or complete the activity) may prevent a claimant from completing a work-related activity. This means that when evaluating upper extremity limitations in the functional criteria, we will find that the relevant functional criterion is satisfied if the claimant is unable to independently initiate or sustain or complete work-related activities involving fine and gross movements due to his or her musculoskeletal disorder. For examples of fine and gross movements, see 1.00E4 and 101.00E4. We will add this additional explanation of our policy to the guidance in EM-21027.

Q23: **What training is SSA providing consultative examiners about this change?**
A23: We have updated or are updating all relevant training materials to reflect this change. We publish instructions for medical providers who conduct consultative examinations. Regarding the musculoskeletal listings, we ask consultative examiners to collect information relevant to the new listings, such as to provide detailed information about the use of assistive devices. For more information, refer to POMS DI 22510.037 (child) and DI 22510.101 (adult).

Q24: **Will SSA publicize analysis that helped inform this change?**
A24: We publicized data and analysis that helped inform this change through the Notice of Proposed Rulemaking (NPRM) and in the preamble to these final rules. On April 16, the Office of the Chief Actuary released additional information about the distributional analysis, including effects by race and ethnicity, related to these final rules, which can be viewed at https://www.ssa.gov/oact/solvency/index.html.

Q25: How will the agency address definitive evidence of the medical need for an assistive device on claims pending with the Appeals Council (AC)? Will the agency call for filing a new application? Will the AC consider the evidence as new and material?
A25: The AC will consider relevant evidence under the revised listings to be new and material if application of the revised criteria would potentially change the outcome of the case (for example, change an unfavorable decision to a favorable decision).