



Supplemental ALJ Training

Social Security Administration

Effect of a Claim's Filing Date on Policies – Side-by-Side Chart

- A claim's filing date is relevant only for the following definitions and policies:

Topic	Claim filed before 3/27/17	Claim filed on or after 3/27/17
AMS	Does not include APRNs, PAs, or audiologists.	Includes APRNs, PAs, and audiologists.
Medical opinion definition	See page 8. Includes diagnosis, prognosis, and statements about symptoms	See page 5. Does not include diagnosis, prognosis, and statements about symptoms.
Other medical evidence definition	Does not include diagnosis, prognosis, and statements about symptoms.	Includes diagnosis, prognosis, and statements about symptoms.
How to consider and provide written analysis about medical opinions and prior administrative medical findings	See pages 8 and 9.	See pages 10 and 11.
Statements on issues reserved to the Commissioner	Written analysis may be required. See page 6.	No written analysis. See page 6.
Decisions by other governmental agencies and nongovernmental entities	Written analysis about the decision itself may be required. See page 7.	No written analysis about the decision itself. See page 7.

- See [DI 24503.050 Determining the Filing Date for Evaluating Evidence](#)

Acceptable Medical Sources (AMS)

- Status as an AMS is relevant for only a few policies:
 - We need objective medical evidence from an AMS to establish the existence of a medically determinable impairment (MDI) at step 2 of the sequential evaluation process
 - Listings
 - A few Listings require additional evidence from an AMS: otologic and audiometric testing for hearing loss, cystic fibrosis, hematological disorders, non-mosaic Down syndrome, genetic photosensitivity disorders, and catastrophic congenital disorder (child claim only)
 - A few Listings often have additional evidence from an AMS: testing for visual disorders, chronic kidney disease on dialysis, and amyotrophic lateral sclerosis (ALS)
 - For claims filed before 3/27/17: Only an AMS can be a treating source, whose medical opinion may get controlling weight
- For all claims, the AMS list includes licensed:
 - Physicians (medical or osteopathic doctors)
 - Psychologists (at the independent practice level)
 - School psychologists (for impairments of intellectual disability, learning disabilities, and borderline intellectual functioning only)
 - May have alternative titles and certification instead of licensure
 - Optometrists (for impairments of visual disorders, or measurement of visual acuity and visual fields only)
 - Podiatrists (for impairments of the foot, or foot and ankle only)
 - Speech-language pathologists (for speech or language impairments only)
 - May have certification instead of licensure
- For claims filed on or after 3/27/17, the AMS list also includes licensed:
 - Advanced Practice Registered Nurses (APRN) (for impairments within the licensed scope of practice)
 - May have alternative titles, such as Advanced Practice Nurse (APN) or Advanced Practice Registered Nurses (APRN)
 - Includes:
 - Certified Nurse Midwife (CNM)
 - Nurse Practitioner (NP)
 - Certified Registered Nurse Anesthetist (CRNA)
 - Clinical Nurse Specialist (CNS)
 - Audiologists (for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only)
 - Physician Assistants (for impairments within the licensed scope of practice)
- See [DI 22505.003 Evidence from an Acceptable Medical Source \(AMS\)](#)

Establishing the existence of an MDI at step 2

- We need objective medical evidence from an AMS to establish the existence of an medically determinable impairment (MDI) at step 2 of the sequential evaluation process
 - Objective medical evidence means: “signs, laboratory findings, or both”
 - **Never** establish an MDI based on an individual’s statement of symptoms, a diagnosis, or a medical opinion
- Definitions
 - **Signs:** one or more anatomical, physiological, or psychological abnormalities that can be observed, apart from your statements (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, and must also be shown by observable facts that can be medically described and evaluated.
 - **Laboratory findings:** one or more anatomical, physiological, or psychological phenomena that can be shown by the use of medically acceptable laboratory diagnostic techniques. Diagnostic techniques include chemical tests (such as blood tests), electrophysiological studies (such as electrocardiograms and electroencephalograms), medical imaging (such as X-rays), and psychological tests.
- See [24501.020 Establishing a Medically Determinable Impairment \(MDI\)](#)

New Categories of Evidence

Each piece of evidence fits into one category of evidence

Category of Evidence	Source	Summary of Definition
Objective medical evidence	Medical sources	Signs, laboratory findings, or both
Medical opinion	Medical sources	<p>For claims filed on or after 3/27/17: A statement about what an individual can still do despite his or her impairment(s) and whether the individual has one or more impairment-related limitations or restrictions in one or more specified abilities:</p> <ul style="list-style-type: none"> • <u>Adult claims:</u> (FOCUS ON RESIDUAL FUNCTIONAL CAPACITY (RFC)) <ul style="list-style-type: none"> • ability to perform physical demands of work activities, • ability to perform mental demands of work activities, • ability to perform other demands of work (using senses), and • ability to adapt to environmental conditions. • <u>T16 child claims:</u> abilities in the 6 domains of functioning <p>For claims filed before 3/27/17: see the definition on page 8</p>
Other medical evidence	Medical sources	All other evidence from medical sources that is not objective medical evidence or a medical opinion
Evidence from nonmedical sources	Nonmedical sources	All evidence from nonmedical sources
Prior administrative medical finding	Medical Consultants (MC) and Psychological Consultants (PC)	A finding, other than the ultimate determination about whether the individual is disabled, about a medical issue made by an MC or PC at a prior administrative level in the current claim

Issues Reserved to the Commissioner

- Statements on issues reserved to the Commissioner are inherently neither valuable nor persuasive to us
- For claims filed on or after March 27, 2017, we will not provide any written analysis about how we consider this evidence
- Consider the context of the statement
- These are the issues reserved to the Commissioner:
 - A statement that a claimant is or is not disabled, blind, able to work, or able to perform regular or continuing work
 - A statement about whether or not a claimant has a severe impairment
 - A statement about whether or not an impairment(s) meets the duration requirement
 - A statement about whether or not an impairment(s) meets or medically equals any listing in the Listing of Impairments
 - In title 16 child claims, a statement about whether or not an impairment(s) functionally equals the listings
 - A statement about what a claimant's RFC is that uses our programmatic terms about the functional exertional levels instead of descriptions about the claimant's functional abilities and limitations
 - A statement about whether or not a claimant's RFC prevents him or her from doing past relevant work
 - A statement that a claimant does or does not meet the requirements of a medical-vocational rule
 - A statement about whether an individual's disability continues or ends when we conduct a continuing disability review
- See [DI 24503.040 Evaluating Statements on Issues Reserved to the Commissioner](#)

Other Governmental Agency and Nongovernmental Entity Decisions

- Other governmental agencies and nongovernmental entities make decisions about disability, blindness, employability, Medicaid, workers' compensation, and other benefits for their programs using their own rules
- They are inherently neither valuable nor persuasive to us
- For claims filed on or after 3/27/17, we will not provide any written analysis about how we consider this evidence
- We may provide written analysis about how we consider the underlying evidence supporting that agency's or entity's decision that we receive
- Never adopt a VA disability rating
- See [DI 24503.045 Evaluating Decisions by Other Government Agencies and Nongovernment Entities](#)

Medical opinions and prior administrative medical findings: Claims filed before 3/27/17: Policies

- Assign a “weight” to each
 - Controlling weight: give a treating source’s medical opinion controlling weight only when it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record
 - Treating source: an AMS who has provided a claimant with medical treatment or evaluation and who has had an ongoing treatment relationship
 - Medical opinion: a statement from an AMS that reflect judgments about the nature and severity of impairment(s), including symptoms, diagnosis and prognosis, what a claimant can still do despite impairment(s), and physical or mental restrictions.
- There are 6 factors to consider (see page 9)
- Articulation requirements
 - Prior administrative medical findings: ODAR adjudicators must always include explanation
 - Medical opinions:
 - If giving controlling weight, then must include an explanation for that medical opinion
 - If not giving controlling weight, then must include an explanation for all medical opinions from AMSs
 - Opinions from medical sources who are not AMSs and from nonmedical sources: should explain the weight given to these opinions or otherwise ensure the discussion of evidence allows a reader to follow our reasoning if the opinion could affect the outcome. We must discuss these opinions when they get more weight than AMS medical opinions.
- See [DI 24503.035 Evaluating and Required Written Analysis about Opinions – Claims filed before March 27, 2017](#)

Medical opinions and prior administrative medical findings: Claims filed before 3/27/17: Factors to consider

- **Examining relationship:** Generally, we give more weight to the medical opinion of a source who has examined a claimant
- **Treatment relationship:**
 - Generally, we give more weight to medical opinions from treating sources
 - Consider
 - Length of the treatment relationship and frequency of examination
 - Nature of the treatment relationship and extent of the treatment relationship
- **Supportability:**
 - The more a medical source presents relevant evidence to support a medical opinion, particularly objective medical evidence, the more weight we will give that medical opinion.
 - The better an explanation a source provides for a medical opinion, the more weight we will give that medical opinion.
- **Consistency:** Generally, the more consistent a medical opinion is with the record as a whole, the more weight we will give to that medical opinion.
- **Specialization:** Generally, we give more weight to the medical opinion of a specialist about medical issues related to his or her area of specialty than to the medical opinion of a source who is not a specialist.
- **Other factors:** Consider any other factors which tend to support or contradict the medical opinion
 - Amount of understanding of our disability programs and their evidentiary requirements
 - The extent to which a medical source is familiar with the other information in a case record
- See [DI 24503.035 Evaluating and Required Written Analysis about Opinions – Claims filed before March 27, 2017](#)

Medical opinions and prior administrative medical findings: Claims filed on or after 3/27/17: Policies

- Consider the persuasiveness of the quality of the evidence
- Do not assign any “weight”
- There is a new definition of “medical opinion” focusing on functional abilities and limitations (see page 4)
- There are 5 factors to consider (see page 11)
- Most important factors are supportability and consistency
- Articulation requirements
 - Must include an explanation about how persuasive we find all medical opinions from all medical sources and all prior administrative medical findings
 - May include an explanation about all of a medical source’s medical opinions together
 - Must include an explanation about the supportability and consistency factors
 - Remaining 3 factors
 - Must discuss when two or more medical opinions or prior administrative medical findings about the same issue are both equally well-supported and consistent but are not exactly the same
 - Discretionary whether to discuss in other situations
- See
 - [DI 24503.025 Evaluating Medical Opinions and Prior Administrative Medical Findings](#)
 - [DI 24503.030 Required Written Analysis about Medical Opinions and Prior Administrative Medical Findings](#)

Medical opinions and prior administrative medical findings: Claims filed on or after 3/27/17: Factors to consider

- **Supportability:** The more relevant the objective medical evidence and supporting explanations presented by a medical source are to support his or her medical opinion(s) or prior administrative medical finding(s), the more persuasive they will be.
- **Consistency:** The more consistent a medical opinion(s) or prior administrative medical finding(s) is with the evidence from other medical sources and nonmedical sources in the claim, the more persuasive they will be.
- **Relationship with the claimant:** This factor combines consideration of these five issues:
 - **Length of the treatment relationship:** The length of time a medical source has treated a claimant may help demonstrate whether the medical source has a longitudinal understanding of the claimant's impairment(s).
 - **Frequency of examinations:** The frequency of a claimant's visits with the medical source may help demonstrate whether the medical source has a longitudinal understanding of the claimant's impairment(s).
 - **Purpose of the treatment relationship:** The purpose for treatment a claimant received from the medical source may help demonstrate the level of knowledge the medical source has of the claimant's impairment(s).
 - **Extent of the treatment relationship:** The kinds and extent of examinations and testing the medical source has performed or ordered from specialists or independent laboratories may help demonstrate the level of knowledge the medical source has of a claimant's impairment(s).
 - **Examining relationship:** A medical source may have a better understanding of a claimant's impairment(s) if he or she examines the claimant than if the medical source only reviews evidence in the folder.
- **Specialization:** The medical opinion or prior administrative medical finding of a medical source who has received advanced education and training to become a specialist may be more persuasive about medical issues related to his or her area of specialty than the medical opinion or prior administrative medical finding of a medical source who is not a specialist in the relevant area of specialty.
- **Other factors:** We will consider other factors that tend to support or contradict a medical opinion or prior administrative medical finding. This includes, but is not limited to, evidence showing a medical source has familiarity with the other evidence in the claim or an understanding of our disability program's policies and evidentiary requirements. When we consider a medical source's familiarity with the other evidence in a claim, we will also consider whether new evidence we receive after the medical source made his or her medical opinion or prior administrative medical finding makes the medical opinion or prior administrative medical finding more or less persuasive.
- See [DI 24503.025 Evaluating Medical Opinions and Prior Administrative Medical Findings](#)

Medical and Psychological Consultants

- **Medical consultants:** Licensed physicians only
- **Psychological consultants:** Licensed psychiatrists or qualified psychologists
 - To be qualified, a psychologist must:
 - (1) Be licensed or certified as a psychologist at the independent practice level of psychology by the State in which he or she practices; AND
 - (2) Either
 - (i) Possess a doctorate degree in psychology from a program in clinical psychology of an educational institution accredited by an organization recognized by the Council on Post-Secondary Accreditation; OR
 - (ii) Be listed in a national register of health service providers in psychology which the Commissioner of Social Security deems appropriate (Note: there is no such list in use currently); AND
 - (3) Possess 2 years of supervised clinical experience as a psychologist in health service, at least 1 year of which is post-masters degree.
- **Initial and reconsideration claims involving physical impairments**
 - We must make every reasonable effort to ensure that a licensed physician has completed the medical portion of the case review and any applicable residual functional capacity (RFC) assessment
 - Both allowances and denials
- **Initial and reconsideration claims involving mental impairments**
 - We must make every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity (RFC) assessment.
 - Both allowances and denials
- See [DI 24501.001 The Disability Determination Services \(DDS\) Disability Examiner \(DE\), Medical Consultant \(MC\), and Psychological Consultant \(PC\) Team, and the Role of the Medical Advisor \(MA\)](#)

Social Security Rulings (SSR)

- We are rescinding four existing SSRs
 - SSR 96-2p: Giving Controlling Weight to Treating Source Medical Opinions
 - SSR 96-5p: Medical Source Opinions on Issues Reserved to the Commissioner
 - SSR 96-6p: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence
 - SSR 06-03p 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
 - We are adding one new SSR to retain current policy about when to obtain medical expert evidence at the hearing and Appeals Council levels
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IV.E.2. EVALUATION OF MEDICAL EVIDENCE

IV.E.2.a. PRIOR RULE -- APPLICABLE TO CLAIMS FILED BEFORE MARCH 27, 2017

§ 404.1527 Evaluating opinion evidence for claims filed before March 27, 2017.

[§ 404.1527. Evaluating opinion evidence.](#)

For claims filed (see § 404.614) before March 27, 2017, the rules in this section apply. For claims filed on or after March 27, 2017, the rules in § 404.1520c apply.

(a) Definitions.

(1) *Medical opinions.* Medical opinions are statements from acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(2) *Treating source.* Treating source means your own acceptable medical source who provides you, or has provided you, with medical treatment or evaluation and who has, or has had, an ongoing treatment relationship with you. Generally, we will consider that you have an ongoing treatment relationship with an acceptable medical source when the medical evidence establishes that you see, or have seen, the source with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for your medical condition(s). We may consider an acceptable medical source who has treated or evaluated you only a few times or only after long intervals (e.g., twice a year) to be your treating source if the nature and frequency of the treatment or evaluation is typical for your condition(s). We will not consider an acceptable medical source to be your treating source if your relationship with the source is not based on your medical need for treatment or evaluation, but solely on your need to obtain a report in support of your claim for disability. In such a case, we will consider the acceptable medical source to be a nontreating source.

(b) *How we consider medical opinions.* In determining whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive. See § 404.1520b.

(c) *How we weigh medical opinions.* Regardless of its source, we will receive. Unless we give a treating source's medical opinion controlling weight under paragraph (c)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) *Examining relationship.* Generally, we give more weight to the medical opinion of a source who has examined you than to the medical opinion of a medical source who has not examined you.

(2) *Treatment relationship.* Generally, we give more weight to medical opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's medical opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's medical opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors in paragraphs (c)(3) through (c)(6) of this section in determining the weight to give the medical opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's medical opinion.

(i) *Length of the treatment relationship and the frequency of examination.* Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the

treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the medical source's medical opinion more weight than we would give it if it were from a nontreating source.

(ii) *Nature and extent of the treatment relationship.* Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her medical opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's medical opinion more weight than we would give it if it were from a nontreating source.

(3) *Supportability.* The more a medical source presents relevant evidence to support a medical opinion, particularly medical signs and laboratory findings, the more weight we will give that medical opinion. The better an explanation a source provides for a medical opinion, the more weight we will give that medical opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their medical opinions will depend on the degree to which they provide supporting explanations for their medical opinions. We will evaluate the degree to which these medical opinions consider all of the pertinent evidence in your claim, including medical opinions of treating and other examining sources.

(4) *Consistency.* Generally, the more consistent a medical opinion is with the record as a whole, the more weight we will give to that medical opinion.

(5) *Specialization.* We generally give more weight to the medical opinion of a specialist about medical issues related to his or her area of specialty than to the medical opinion of a source who is not a specialist.

(6) *Other factors.* When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the medical opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that a medical source has, regardless of the source of that understanding, and the extent to which a medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(d) *Medical source opinions on issues reserved to the Commissioner.* Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(1) of this section, but are, instead, opinions on issues reserved to the

Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) *Opinions that you are disabled.* We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled.

(2) *Other opinions on issues reserved to the Commissioner.* We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to this subpart, your residual functional capacity (see §§ 404.1545 and 404.1546), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (d)(1) and (d)(2) of this section.

(e) *Evidence from our Federal or State agency medical or psychological consultants.* The rules in § 404.1513a apply except that when an administrative law judge gives controlling weight to a treating source's medical opinion, the administrative law judge is not required to explain in the decision the weight he or she gave to the prior administrative medical findings in the claim.

(f) *Opinions from medical sources who are not acceptable medical sources and from nonmedical sources.*

(1) *Consideration.* Opinions from medical sources who are not acceptable medical sources and from nonmedical sources may reflect the source's judgment about some of the same issues addressed in medical opinions from acceptable medical sources. Although we will consider these opinions using the same factors as listed in paragraph (c)(1) through (c)(6) in this section, not every factor for weighing opinion evidence will apply in every case because the evaluation of an opinion from a medical source who is not an acceptable medical source or from a nonmedical source depends on the particular facts in each case. Depending on the particular facts in a case, and after applying the factors for weighing opinion evidence, an opinion from a medical source who is not an acceptable medical source or from a nonmedical source may outweigh the medical opinion of an acceptable medical source, including the medical opinion of a treating source. For example, it may be appropriate to give more weight to the opinion of a medical source who is not an "acceptable medical source" if he or she has seen the individual more often than the treating source, has provided better supporting

evidence and a better explanation for the opinion, and the opinion is more consistent with the evidence as a whole.

(2) *Articulation*. The adjudicator generally should explain the weight given to opinions from these sources or otherwise ensure that the discussion of the evidence in the determination or decision allows a claimant or subsequent reviewer to follow the adjudicator's reasoning, when such opinions may have an effect on the outcome of the case. In addition, when an adjudicator determines that an opinion from such a source is entitled to greater weight than a medical opinion from a treating source, the adjudicator must explain the reasons in the notice of decision in hearing cases and in the notice of determination (that is, in the personalized disability notice) at the initial and reconsideration levels, if the determination is less than fully favorable.

IV.E.2.b. CURRENT RULE -- APPLICABLE TO CLAIMS FILED ON OR AFTER MARCH 27, 2017

§ 404.1520c How we consider and articulate medical opinions and prior administrative medical findings for claims filed on or after March 27, 2017.

§ 404.1520(c)

For claims filed (see § 404.614) on or after March 27, 2017, the rules in this section apply. For claims filed before March 27, 2017, the rules in § 404.1527 apply.

(a) *How we consider medical opinions and prior administrative medical findings*. We will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources. When a medical source provides one or more medical opinions or prior administrative medical findings, we will consider those medical opinions or prior administrative medical findings from that medical source together using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. The most important factors we consider when we evaluate the persuasiveness of medical opinions and prior administrative medical findings are supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section). We will articulate how we considered the medical opinions and prior administrative medical findings in your claim according to paragraph (b) of this section.

(b) *How we articulate our consideration of medical opinions and prior administrative medical findings*. We will articulate in our determination or decision how persuasive we find all of the medical opinions and all of the prior administrative medical findings in your case record. Our articulation requirements are as follows:

(1) *Source-level articulation.* Because many claims have voluminous case records containing many types of evidence from different sources, it is not administratively feasible for us to articulate in each determination or decision how we considered all of the factors for all of the medical opinions and prior administrative medical findings in your case record. Instead, when a medical source provides multiple medical opinion(s) or prior administrative medical finding(s), we will articulate how we considered the medical opinions or prior administrative medical findings from that medical source together in a single analysis using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. We are not required to articulate how we considered each medical opinion or prior administrative medical finding from one medical source individually.

(2) *Most important factors.* The factors of supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section) are the most important factors we consider when we determine how persuasive we find a medical source's medical opinions or prior administrative medical findings to be. Therefore, we will explain how we considered the supportability and consistency factors for a medical source's medical opinions or prior administrative medical findings in your determination or decision. We may, but are not required to, explain how we considered the factors in paragraphs (c)(3) through (c)(5) of this section, as appropriate, when we articulate how we consider medical opinions and prior administrative medical findings in your case record.

(3) *Equally persuasive medical opinions or prior administrative medical findings about the same issue.* When we find that two or more medical opinions or prior administrative medical findings about the same issue are both equally well-supported (paragraph (c)(1) of this section) and consistent with the record (paragraph (c)(2) of this section) but are not exactly the same, we will articulate how we considered the other most persuasive factors in paragraphs (c)(3) through (c)(5) of this section for those medical opinions or prior administrative medical findings in your determination or decision.

(c) *Factors.* We will consider the following factors when we consider the medical opinion(s) and prior administrative medical finding(s) in your case:

(1) *Supportability.* The more relevant the objective medical evidence and supporting explanations presented by a medical source are to support his or her medical opinion(s) or prior administrative medical finding(s), the more persuasive the medical opinions or prior administrative medical finding(s) will be.

(2) *Consistency.* The more consistent a medical opinion(s) or prior administrative medical finding(s) is with the evidence from other medical sources and nonmedical sources in the claim, the more persuasive the medical opinion(s) or prior administrative medical finding(s) will be.

(3) *Relationship with the claimant.* This factor combines consideration of the issues in paragraphs (c)(3)(i) through (v) of this section.

(i) *Length of the treatment relationship.* The length of time a medical source has treated you may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(ii) *Frequency of examinations.* The frequency of your visits with the medical source may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(iii) *Purpose of the treatment relationship.* The purpose for treatment you received from the medical source may help demonstrate the level of knowledge the medical source has of your impairment(s).

(iv) *Extent of the treatment relationship.* The kinds and extent of examinations and testing the medical source has performed or ordered from specialists or independent laboratories may help demonstrate the level of knowledge the medical source has of your impairment(s).

(v) *Examining relationship.* A medical source may have a better understanding of your impairment(s) if he or she examines you than if the medical source only reviews evidence in your folder.

(4) *Specialization.* The medical opinion or prior administrative medical finding of a medical source who has received advanced education and training to become a specialist may be more persuasive about medical issues related to his or her area of specialty than the medical opinion or prior administrative medical finding of a medical source who is not a specialist in the relevant area of specialty.

(5) *Other factors.* We will consider other factors that tend to support or contradict a medical opinion or prior administrative medical finding. This includes, but is not limited to, evidence showing a medical source has familiarity with the other evidence in the claim or an understanding of our disability program's policies and evidentiary requirements. When we consider a medical source's familiarity with the other evidence in a claim, we will also consider whether new evidence we receive after the medical source made his or her medical opinion or prior administrative medical finding makes the medical opinion or prior administrative medical finding more or less persuasive.

(d) *Evidence from nonmedical sources.* We are not required to articulate how we considered evidence from nonmedical sources using the requirements in paragraphs (a)–(c) in this section.

IV.E.3. Acceptable Medical Sources

IV.E.3.a. Prior Rule – Acceptable Medical Sources – Before 3/27/17

§ 404.1513. Medical and other evidence of your impairment(s).

(a) **Sources who can provide evidence to establish an impairment.** We need evidence from acceptable medical sources to establish whether you have a medically determinable impairment(s). See § 404.1508. Acceptable medical sources are—

- (1) Licensed physicians (medical or osteopathic doctors);
- (2) Licensed or certified psychologists. Included are school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, for purposes of establishing intellectual disability, learning disabilities, and borderline intellectual functioning only;
- (3) Licensed optometrists, for purposes of establishing visual disorders only (except, in the U.S. Virgin Islands, licensed optometrists, for the measurement of visual acuity and visual fields only);
- (4) Licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle; and
- (5) Qualified speech-language pathologists, for purposes of establishing speech or language impairments only. For this source, “qualified” means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of Clinical Competence from the American Speech-Language-Hearing Association.

IV.E.3.b Current Rule – Acceptable Medical Source – 3/27/17 and after

§ 404.1502 Definitions for this subpart.

As used in the subpart—

Acceptable medical source means a medical source who is a:

- (1) Licensed physician (medical or osteopathic doctor);

- (2) Licensed psychologist, which includes:
- (i) A licensed or certified psychologist at the independent practice level; or
 - (ii) A licensed or certified school psychologist, or other licensed or certified individual with another title who performs the same function as a school psychologist in a school setting, for impairments of intellectual disability, learning disabilities, and borderline intellectual functioning only;
- (3) Licensed optometrist for impairments of visual disorders, or measurement of visual acuity and visual fields only, depending on the scope of practice in the State in which the optometrist practices;
- (4) Licensed podiatrist for impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle;
- (5) Qualified speech-language pathologist for speech or language impairments only. For this source, *qualified* means that the speechlanguage pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of Clinical Competence in Speech-Language Pathology from the American Speech-Language-Hearing Association;
- (6) Licensed audiologist for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only (with respect to claims filed (see § 404.614) on or after March 27, 2017);
- (7) Licensed Advanced Practice Registered Nurse, or other licensed advanced practice nurse with another title, for impairments within his or her licensed scope of practice (only with respect to claims filed (see § 404.614) on or after March 27, 2017); or
- (8) Licensed Physician Assistant for impairments within his or her licensed scope of practice (only with respect to claims filed (see § 404.614) on or after March 27, 2017).

Commissioner means the Commissioner of Social Security or his or her authorized designee.

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

Medical source means an individual who is licensed as a healthcare worker by a State and working within the scope of practice permitted under State or Federal law, or an individual who is certified by a State as a speech-language pathologist or a school

psychologist and acting within the scope of practice permitted under State or Federal law.

Nonmedical source means a source of evidence who is not a medical source.

This includes, but is not limited to:

- (1) You;
- (2) Educational personnel (for example, school teachers, counselors, early intervention team members, developmental center workers, and daycare center workers);
- (3) Public and private social welfare agency personnel; and
- (4) Family members, caregivers, friends, neighbors, employers, and clergy.

Objective medical evidence means signs, laboratory findings, or both.

Signs means one or more anatomical, physiological, or psychological abnormalities that can be observed, apart from your statements (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, and must also be shown by observable facts that can be medically described and evaluated.

State agency means an agency of a State designated by that State to carry out the disability or blindness determination function.

Symptoms means your own description of your physical or mental impairment.

We or us means, as appropriate, either the Social Security Administration or the State agency making the disability or blindness determination.

You or your means, as appropriate, the person who applies for benefits or for a period of disability, the person for whom an application is filed, or the person who is receiving benefits based on disability or blindness.

IV.E.3.b. EVALUATION OF NON-AMS OPINIONS

IV.E.3.b.(i) Prior Rule – Non AMS Opinions – Before 3/27/17

20 CFR 404.1527(f)

(f) *Opinions from medical sources who are not acceptable medical sources and from nonmedical sources.*

(1) *Consideration.* Opinions from medical sources who are not acceptable medical sources and from nonmedical sources may reflect the source's judgment about some of the same issues addressed in medical opinions from acceptable medical sources. Although we will consider these opinions using the same factors as listed in paragraph (c)(1) through (c)(6) in this section, not every factor for weighing opinion evidence will apply in every case because the evaluation of an opinion from a medical source who is not an acceptable medical source or from a nonmedical source depends on the particular facts in each case. Depending on the particular facts in a case, and after applying the factors for weighing opinion evidence, an opinion from a medical source who is not an acceptable medical source or from a nonmedical source may outweigh the medical opinion of an acceptable medical source, including the medical opinion of a treating source. For example, it may be appropriate to give more weight to the opinion of a medical source who is not an "acceptable medical source" if he or she has seen the individual more often than the treating source, has provided better supporting evidence and a better explanation for the opinion, and the opinion is more consistent with the evidence as a whole.

(2) *Articulation.* The adjudicator generally should explain the weight given to opinions from these sources or otherwise ensure that the discussion of the evidence in the determination or decision allows a claimant or subsequent reviewer to follow the adjudicator's reasoning, when such opinions may have an effect on the outcome of the case. In addition, when an adjudicator determines that an opinion from such a source is entitled to greater weight than a medical opinion from a treating source, the adjudicator must explain the reasons in the notice of decision in hearing cases and in the notice of determination (that is, in the personalized disability notice) at the initial and reconsideration levels, if the determination is less than fully favorable.

IV.E.3.b.(ii) Current Rule – Medical opinions – 3/27/17 and after **20 CFR 404.1520c(a)**

(a) *How we consider medical opinions and prior administrative medical findings.* We will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources. When a medical source provides one or more medical opinions or prior administrative medical findings, we will consider those medical opinions or prior administrative medical findings from that medical source together using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. The most important factors we consider when we evaluate the persuasiveness of medical opinions and prior administrative medical findings are supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section). We will articulate how we considered the medical opinions and prior administrative medical findings in your claim according to paragraph (b) of this section.

IV.E.4. SDM FINDINGS

CALJ Memo, 10-1691; Consideration of SDM Residual Functional Capacity Assessments and Other Findings -- REVISED

IV.E.5. Medical Source Opinions on Issues Reserved to the Commissioner

IV.E.5.a. PRIOR RULE; NOW APPLICABLE ONLY TO CLAIMS FILED BEFORE MARCH 27, 2017

20 CFR 404.1527(d)

(d) *Medical source opinions on issues reserved to the Commissioner.* Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(1) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) *Opinions that you are disabled.* We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled.

(2) *Other opinions on issues reserved to the Commissioner.* We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to this subpart, your residual functional capacity (see §§ 404.1545 and 404.1546), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (d)(1) and (d)(2) of this section.

**IV.E.5.b. CURRENT RULE; APPLICABLE TO CASES FILED ON OR AFTER
MARCH 27, 2017**

20 CFR 404.1520b(c)

(c) *Evidence that is inherently neither valuable nor persuasive.* Paragraphs (c)(1) through (c)(3) apply in claims filed (see § 404.614) on or after March 27, 2017. Because the evidence listed in paragraphs (c)(1) through (c)(3) of this section is inherently neither valuable nor persuasive to the issue of whether you are disabled or blind under the Act, we will not provide any analysis about how we considered such evidence in our determination or decision, even under § 404.1520c:

(1) *Decisions by other governmental agencies and nongovernmental entities.* See § 404.1504.

(2) *Disability examiner findings.* Findings made by a State agency disability examiner made at a previous level of adjudication about a medical issue, vocational issue, or the ultimate determination about whether you are disabled.

(3) *Statements on issues reserved to the Commissioner.* The statements listed in paragraphs (c)(3)(i) through (c)(3)(viii) of this section would direct our determination or decision that you are or are not disabled or blind within the meaning of the Act, but we are responsible for making the determination or decision about whether you are disabled or blind:

(i) Statements that you are or are not disabled, blind, able to work, or able to perform regular or continuing work;

(ii) Statements about whether or not you have a severe impairment(s);

(iii) Statements about whether or not your impairment(s) meets the duration requirement (see § 404.1509);

(iv) Statements about whether or not your impairment(s) meets or medically equals any listing in the Listing of Impairments in Part 404, Subpart P, Appendix 1;

(v) Statements about what your residual functional capacity is using our programmatic terms about the functional exertional levels in Part 404, Subpart P, Appendix 2, Rule 200.00 instead of descriptions about your functional abilities and limitations (see § 404.1545);

(vi) Statements about whether or not your residual functional capacity prevents you from doing past relevant work (see § 404.1560);

(vii) Statements that you do or do not meet the requirements of a medicalvocational rule in Part 404, Subpart P, Appendix 2; and

(viii) Statements about whether or not your disability continues or ends when we conduct a continuing disability review (see § 404.1594).

IV.E.6. DETERMINATIONS BY OTHER GOVERNMENTAL OR NON-GOVERNMENTAL BODIES (See CALJ Memo on Page 142)

IV.E.6.a. PRIOR RULE; NOW APPLICABLE ONLY TO CLAIMS FILED BEFORE MARCH 27, 2017

§ 404.1504. Determinations by other organizations and agencies.

A decision by any nongovernmental agency or any other governmental agency about whether you are disabled or blind is based on its rules and is not our decision about whether you are disabled or blind. We must make a disability or blindness determination based on social security law. Therefore, a determination made by another agency that you are disabled or blind is not binding on us.

§ 404.1527(f). Opinions from medical sources who are not acceptable medical sources and from nonmedical sources.

(1) Consideration. Opinions from medical sources who are not acceptable medical sources and from nonmedical sources may reflect the source's judgment about some of the same issues addressed in medical opinions from acceptable medical sources. Although we will consider these opinions using the same factors as listed in paragraph (c)(1) through (c)(6) in this section, not every factor for weighing opinion evidence will apply in every case because the evaluation of an opinion from a medical source who is not an acceptable medical source or from a nonmedical source depends on the particular facts in each case. Depending on the particular facts in a case, and after applying the factors for weighing opinion evidence, an opinion from a medical source who is not an acceptable medical source or from a nonmedical source may outweigh the medical opinion of an acceptable medical source, including the medical opinion of a treating source. For example, it may be appropriate to give more weight to the opinion of a medical source who is not an "acceptable medical source" if he or she has seen the individual more often than the treating source, has provided better

supporting evidence and a better explanation for the opinion, and the opinion is more consistent with the evidence as a whole.

(2) *Articulation*. The adjudicator generally should explain the weight given to opinions from these sources or otherwise ensure that the discussion of the evidence in the determination or decision allows a claimant or subsequent reviewer to follow the adjudicator's reasoning, when such opinions may have an effect on the outcome of the case. In addition, when an adjudicator determines that an opinion from such a source is entitled to greater weight than a medical opinion from a treating source, the adjudicator must explain the reasons in the notice of decision in hearing cases and in the notice of determination (that is, in the personalized disability notice) at the initial and reconsideration levels, if the determination is less than fully favorable.

IV.E.6.b CURRENT RULE; APPLICABLE ONLY TO CLAIMS ON OR AFTER MARCH 27, 2017

§ 404.1504 Decisions by other governmental agencies and nongovernmental entities.

Other governmental agencies and nongovernmental entities—such as the Department of Veterans Affairs, the Department of Defense, the Department of Labor, the Office of Personnel Management, State agencies, and private insurers—make disability, blindness, employability, Medicaid, workers' compensation, and other benefits decisions for their own programs using their own rules. Because a decision by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits is based on its rules, it is not binding on us and is not our decision about whether you are disabled or blind under our rules.

Therefore, in claims filed (see § 404.614) on or after March 27, 2017, we will not provide any analysis in our determination or decision about a decision made by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits. However, we will consider all of the supporting evidence underlying the other governmental agency or nongovernmental entity's decision that we receive as evidence in your claim in accordance with § 404.1513(a)(1) through(4).

20 CFR 404.1450b(c)(1)

(c) *Evidence that is inherently neither valuable nor persuasive.* Paragraphs (c)(1) through (c)(3) apply in claims filed (see § 404.614) on or after March 27, 2017. Because the evidence listed in paragraphs (c)(1) through (c)(3) of this section is inherently neither valuable nor persuasive to the issue of whether you are disabled or blind under the Act, we will not provide any analysis about how we considered such evidence in our determination or decision, even under § 404.1520c:

(1) *Decisions by other governmental agencies and nongovernmental entities.* See § 404.1504.

IV.E.7. ADMINISTRATIVE FINDINGS BY DDS AND OTHER PROGRAM PHYSICIANS AND PSYCHOLOGISTS

IV.E.7.a. PRIOR RULE; NOW APPLICABLE ONLY TO CLAIMS FILED BEFORE MARCH 27, 2017

404.1527(e)

(e) *Opinions of nonexamining sources.* We consider all evidence from nonexamining sources to be opinion evidence. When we consider the opinions of nonexamining sources, we apply the rules in paragraphs (a) through (d) of this section. In addition, the following rules apply to State agency medical and psychological consultants, other program physicians and psychologists, and medical experts we consult in connection with administrative law judge hearings and Appeals Council review:

(1) In claims adjudicated by the State agency, a State agency medical or psychological consultant may make the determination of disability together with a State agency disability examiner or provide one or more medical opinions to a State agency disability examiner when the disability examiner makes the initial or reconsideration determination alone (see § 404.1615(c) of this part). The following rules apply:

(i) When a State agency medical or psychological consultant makes the determination together with a State agency disability examiner at the initial or reconsideration level of the administrative review process as provided in § 404.1615(c)(1), he or she will consider the evidence in your case record and make findings of fact about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or medically equals the requirements for any impairment listed in appendix 1 to this

subpart, and your residual functional capacity. These administrative findings of fact are based on the evidence in your case but are not in themselves evidence at the level of the administrative review process at which they are made.

(ii) When a State agency disability examiner makes the initial determination alone as provided in § 404.1615(c)(3), he or she may obtain the opinion of a State agency medical or psychological consultant about one or more of the medical issues listed in paragraph (e)(1)(i) of this section. In these cases, the State agency disability examiner will consider the opinion of the State agency medical or psychological consultant as opinion evidence and weigh this evidence using the relevant factors in paragraphs (a) through (e) of this section.

(iii) When a State agency disability examiner makes a reconsideration determination alone as provided in § 404.1615(c)(3), he or she will consider findings made by a State agency medical or psychological consultant at the initial level of the administrative review process and any opinions provided by such consultants at the initial and reconsideration levels as opinion evidence and weigh this evidence using the relevant factors in paragraphs (a) through (e) of this section.

(2) Administrative law judges are responsible for reviewing the evidence and making findings of fact and conclusions of law. They will consider opinions of State agency medical or psychological consultants, other program physicians and psychologists, and medical experts as follows:

(i) Administrative law judges are not bound by any findings made by State agency medical or psychological consultants, or other program physicians or psychologists. State agency medical and psychological consultants and other program physicians, psychologists, and other medical specialists are highly qualified physicians, psychologists, and other medical specialists who are also experts in Social Security disability evaluation. Therefore, administrative law judges must consider findings and other opinions of State agency medical and psychological consultants and other program physicians, psychologists, and other medical specialists as opinion evidence, except for the ultimate determination about whether you are disabled (see § 404.1512(b)(8)).

(ii) When an administrative law judge considers findings of a State agency medical or psychological consultant or other program physician, psychologist, or other medical specialist, the administrative law judge will evaluate the findings using the relevant factors in paragraphs (a) through (d) of this section, such as the consultant's medical specialty and expertise in our rules, the supporting evidence in the case record, supporting explanations the medical or psychological consultant provides, and any other factors relevant to the weighing of the opinions. Unless a treating source's opinion is given controlling weight, the administrative law judge must explain in the decision the weight given to the opinions of a State agency

medical or psychological consultant or other program physician, psychologist, or other medical specialist, as the administrative law judge must do for any opinions from treating sources, nontreating sources, and other nonexamining sources who do not work for us.

(iii) Administrative law judges may also ask for and consider opinions from medical experts on the nature and severity of your impairment(s) and on whether your impairment(s) equals the requirements of any impairment listed in appendix 1 to this subpart. When administrative law judges consider these opinions, they will evaluate them using the rules in paragraphs (a) through (d) of this section.

(3) When the Appeals Council makes a decision, it will follow the same rules for considering opinion evidence as administrative law judges follow.

404.1513a

(a) *Sources who can provide evidence to establish an impairment.* We need evidence from acceptable medical sources to establish whether you have a medically determinable impairment(s). See § 404.1508. Acceptable medical sources are—

- (1) Licensed physicians (medical or osteopathic doctors);
- (2) Licensed or certified psychologists. Included are school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, for purposes of establishing intellectual disability, learning disabilities, and borderline intellectual functioning only;
- (3) Licensed optometrists, for purposes of establishing visual disorders only (except, in the U.S. Virgin Islands, licensed optometrists, for the measurement of visual acuity and visual fields only);
- (4) Licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle; and
- (5) Qualified speech-language pathologists, for purposes of establishing speech or language impairments only. For this source, "qualified" means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of

Clinical Competence from the American Speech-Language-Hearing Association.

IV.E.7.b. CURRENT RULE; APPLICABLE ONLY TO CLAIMS ON OR AFTER MARCH 27, 2017

404.1520c(a)

(a) *How we consider medical opinions and prior administrative medical findings.* We will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources. When a medical source provides one or more medical opinions or prior administrative medical findings, we will consider those medical opinions or prior administrative medical findings from that medical source together using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. The most important factors we consider when we evaluate the persuasiveness of medical opinions and prior administrative medical findings are supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section). We will articulate how we considered the medical opinions and prior administrative medical findings in your claim according to paragraph (b) of this section.

IV.E.8. Global Assessment of Function (GAF) Evidence in Disability Adjudication Scores

AM-13066 REV 2

Instruction

Identification Number	AM-13066 REV 2	Effective Date: June 28, 2017
Intended Audience:	CSTs/ODAR/DDSs/OMVE/OQR/CO	
Originating Office:	ORDP ODP	
Title:	Global Assessment of Functioning (GAF) Evidence in Disability Adjudication - REV	
Type:	AM - Admin Messages	
Program:	Disability	
Link To Reference:	See References at the end of this AM.	

Retention Date: December 28, 2017

Revision 06/28/2017: We revised this Administrative Message (AM) to make it consistent with the final rules, "Revisions to Rules Regarding the Evaluation of Medical Evidence," effective on March 27, 2017.

A. Purpose

This AM provides guidance to all State and Federal adjudicators (including administrative law judges) on how to consider Global Assessment of Functioning (GAF) ratings when assessing disability claims involving mental disorders. Specifically, for claims filed on or after March 27, 2017, we consider a GAF score to be “other medical evidence.” For details, see section E.

B. Background

The previous version of this AM mentioned the Daily Living Assessment-20 (DLA-20) in the first paragraph along with the discussion of GAF ratings, but did not state how adjudicators should characterize the DLA-20. The DLA-20 is a standardized psychological instrument that allows for estimated GAF ratings:

- For claims filed prior to March 27, 2017, we consider the DLA-20 to be medical evidence.
- For claims filed on or after 3/27/17, we consider the DLA-20 to be other medical evidence.

The DLA-20 is a measure of functioning, but it differs from the GAF in some significant ways. First, it does fall into the category of a standardized psychological instrument. It has validation studies including inter-rater reliability testing. Second, unlike the GAF, the clinician is rating 20 specific activities across five domains. The rating for each behavior is on a 7-point scale and the test materials provide descriptive anchors for each rating point. Characterization of the DLA-20 as medical evidence for claims filed prior to March 27, 2017 and as other evidence for claims filed on or after March 27, 2017 is similar to our guidance on other rating scales. With any standardized instrument, we do not rely on scores alone, but rather on the supporting evidence about the individual’s functioning.

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published periodically by the American Psychiatric Association (APA), provides the common language and standard criteria for classification of mental disorders. The DSM, Fourth Edition, Text Revision (DSM-IV-TR) provided for a multi-axial assessment of mental disorders with Axis V being a GAF rating.

The APA published a fifth edition ([DSM-5](#)) on June 1, 2013, that does not include GAF rating for assessment of mental disorders. However, we continue to receive and consider GAF in medical evidence. This guidance relates to the evaluation of this evidence.

C. What is the GAF?

The GAF is a rating reporting a medical source’s judgment of an individual’s overall ability to function in daily life. It reflects the medical source’s subjective judgment about the individual’s symptom severity and psychological, social, and occupational functioning. The rating does not reflect impairment in function caused by physical or environmental limitations.

Each 10-point range (decile) within the GAF has two components:

1. symptom severity, and
2. functioning

A GAF rating is within a particular decile if either the symptom severity or the level of functioning falls within the range. In situations where an individual's symptom severity and level of functioning differ, the final GAF rating always reflects the worse of the two, but the multi-axis diagnosis will not clearly indicate whether the GAF assigned reflects the symptom severity or level of functioning. In other words, the single score is a numeric representation reflecting the worse of an individual's symptom severity or overall functioning involving mental demands without clarity about which of those two the score represents.

By definition, it is not clear what any GAF score actually represents or upon which symptom(s) or functional limitations it may rely.

For example, a person with a number of psychological symptoms and very few functional limitations could receive a GAF rating consistent with his or her reported psychological symptoms.

D. Problems with using the GAF to evaluate disability

Some medical sources gave inflated or unrealistically low GAF ratings because the GAF rating instructions in the DSM-IV-TR were unclear. Inter-rater reliability ratings are low in the clinical setting because there is great variability of training and experience levels amongst clinicians. These rating problems, alone or in combination, can lead to improper assessment of impairment severity. Because of the four drawbacks below, adjudicators should not rely on GAF evidence as the primary support for findings of impairment severity or of mental limitations:

1. GAF ratings are not standardized

GAF ratings lack standardization, meaning adjudicators cannot draw reliable inferences from differences in GAF ratings assigned by different medical sources or from a single GAF rating. A GAF rating compares a patient with the distinctive population of patients the source has known. This process limits direct comparability of GAF ratings assigned by different evaluators or even by the same evaluator at substantially different points in time.

Although the GAF rating is numerical, the actual number assigned can be misleading because the rating does not quantify differences in function between people.

For example, a GAF rating of 75 does not mean a person was functioning 10 units better than a person with a score of 65 was, nor does a GAF of 40 indicate a person was functioning half as well as a person with a score of 80.

2. GAF ratings need supporting detail

The GAF Scale anchors are very general and there can be a significant variation in how medical sources rated a GAF.

For example, if an individual had a GAF of 20, it could mean that he or she was not maintaining minimal personal hygiene (a clinical observation) or that he or she had some potential to hurt himself, herself, or others (a clinical judgment). Evaluators rarely noted whether the score reflected function, symptoms, or both.

3. GAF ratings are not specific

A GAF rating is not specific enough to be useful to determine symptom severity or limitation in a specific mental functional ability. By definition, it is not clear what any GAF score actually represents or upon which symptom(s) or functional limitations it may rely.

4. GAF ratings lack longitudinal context

A GAF rating is only a snapshot about symptom severity and level of functioning. A GAF rating is usually an estimate of the best level of functioning over the last week or so, or over the entirety of the past year. It rarely overrides a more specific longitudinal picture. Unless the medical source clearly explains the reasons behind his or her GAF rating and the period to which the rating applies, the GAF rating does not help provide a reliable longitudinal picture of the claimant's alleged impairments.

E. GAF ratings as evidence

An adjudicator considers a GAF rating as evidence in a claim. However, as explained above, several problems with a GAF rating make it inherently of little evidentiary value in our adjudication process.

- 1. Claims filed on or after March 27, 2017.** For claims with a filing date on or

after March 27, 2017, we categorize a GAF rating as “other medical evidence” because:

- It includes consideration of symptoms categorized as other medical evidence, under our regulations. More specifically, for claims filed as of this date, our regulations indicate that a medical opinion does not include a statement about symptoms. For claims filed as of this date, our regulations define a medical opinion as a statement from a medical source about what the claimant can still do despite the impairment(s) and whether the claimant has one or more impairment-related limitations or restrictions. Thus, a GAF rating is not a medical opinion;
- The single score is a numeric representation reflecting the worse of the individual’s symptom severity or overall functioning involving mental demands without clarity about which of those two the score represents; and
- If the score reflects functioning involving mental demands, it is not specified which specific mental abilities are being reflected in the score, rendering it not useful in assessing functioning.

Adjudicators follow the articulation requirements for this category of evidence as provided in our regulations and POMS.

2. Claims filed before March 27, 2017. For claims with a filing date before March 27, 2017, we categorize a GAF rating as a “medical opinion” if it was made by an acceptable medical source (AMS) or as an “opinion” if it was made by a medical source who is not an AMS. For claims filed prior to March 27, 2017, our regulations define a medical opinion as a statement from an AMS that reflects judgments about the nature and severity of the claimant’s impairments; including symptoms, diagnosis, and prognosis, as well as what the claimant can still do despite the impairments. Adjudicators will follow the articulation requirements for these categories of evidence as provided in our regulations and POMS.

F. Guidance about how to consider GAF within the sequential evaluation process

A GAF rating alone is never dispositive of impairment severity. **DO NOT:**

1. Use a GAF rating as objective medical evidence that the claimant has a medically determinable mental impairment.

A GAF rating is neither a sign nor a laboratory finding that you can use as a basis for concluding that the claimant has a medically determinable impairment.

2. Rely solely upon a GAF rating to support a disability determination or decision.

When case evidence includes a GAF rating from a medical source, the adjudicator must consider the GAF rating and the medical source's support for assigning that specific rating, along with all of the relevant evidence in the claim. In cases where there are multiple GAF ratings from a provider, the articulation requirement for claims filed before March 27, 2017 can be addressed through a "representative" GAF rating if the GAF scores are similar or, when the GAF ratings are significantly divergent, by addressing whether the range of GAF ratings is supported by the evidence of record.

3. Equate any particular GAF rating with a listing-level limitation.

The adjudicator cannot use a GAF rating to determine whether a claimant's impairment meets the diagnostic criteria of intellectual disorder in listing 12.05, because the rating lacks specificity, may not reflect a claimant's functioning over time, and is not a standardized measure of anything, including intelligence or adaptive behavior.

4. Equate a particular GAF rating with a particular mental residual functional capacity assessment.

The GAF rating does not measure the ability to meet the mental demands of unskilled work. There have been no published studies of how, or if, GAF ratings relate to meeting the demands of unskilled work. Additionally, there is no correlation between GAF ratings and the B criteria in the mental disorders listings.

For evaluation and articulation requirements for evidence, see POMS [DI 24503.001](#) through [DI 24503.050](#).

Questions

Direct all program-related and technical questions to your Regional Office (RO) support staff or Program Service Center (PSC) Operations Analysis (OA) staff. RO support staff or PSC OA staff may refer questions or problems to their Central Office contacts. The Office of Disability Adjudication and Review (ODAR) personnel should direct questions through their management chain.

References:

[20 CFR 404.1502](#) General definitions and terms for subpart P

[20 CFR 416.902](#) General definitions and terms for subpart I

20 CFR 404.1513 Categories of evidence

20 CFR 404.913 Categories of evidence

[20 CFR 404.1520a](#) Evaluation of mental impairments

[20 CFR 416.920a](#) Evaluation of mental impairments

[20 CFR 404.1527](#) Evaluating opinion evidence for claims filed before March 27, 2017

[20 CFR 416.927](#) Evaluating opinion evidence for claims filed before March 27, 2017
20 CFR 404.1520c How we consider and articulate medical opinions and prior administrative medical findings for claims filed on or after March 27, 2017
20 CFR 416.920C How we consider and articulate medical opinions and prior administrative medical findings for claims filed on or after March 27, 2017
[DI 22505.001](#) Medical and Nonmedical Evidence
[DI 22505.003](#) Evidence from an Acceptable Medical Source (AMS)
[DI 22505.007](#) Developing Initial Evidence from Medical Sources
[DI 24510.065](#) Section III of SSA-4734-F4-SUP Functional Capacity Assessment
[DI 24503.001](#) Evaluating Evidence – Basic Policy
[DI 24503.005](#) Categories of Evidence
[DI 24503.010](#) Evaluating Objective Medical Evidence
[DI 24503.015](#) Evaluating Other Medical Evidence
[DI 24503.020](#) Evaluating Evidence from Nonmedical Sources
[DI 24503.025](#) Evaluating Medical Opinions and Prior Administrative Medical Findings – Claims filed on or after March 27, 2017
[DI 24503.030](#) Articulation Requirements for Medical Opinions and Prior Administrative Medical Filings – Claims Filed before March 27, 2017
[DI 26530.015](#) Personalized Disability Explanation in Initial Closed Period and Unfavorable Onset Date Allowances
[DI 26530.020](#) Personalized Disability Explanation in Initial Denials
[DI 33015.020](#) Writing the Disability Hearing Officer's (DHO's) Decision
[HALLEX 1-2-5-1](#) Evidence – General
[HALLEX 1-2-5-14](#) Obtaining Medical Evidence from a Medical Source
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IV.F. Evaluation of Symptoms

IV.F.1. How we evaluate symptoms, including pain: 20 CFR § 404.1529

§ 404.1529 How we evaluate symptoms, including pain.

(a) *General.* In determining whether you are disabled, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence. We will consider all of your statements about your symptoms, such as pain, and any description your medical sources or nonmedical sources may provide about how the symptoms affect your activities of daily living and your ability to work. However, statements about your pain or other symptoms will not alone establish that you are disabled. There must be objective medical evidence from an acceptable medical source that shows you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and that, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings, and statements about how your symptoms affect you. We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work.

* * * *

(c) * * *

(1) * * * In evaluating the intensity and persistence of your symptoms, we consider all of the available evidence from your medical sources and nonmedical sources about how your symptoms affect you. We also consider the medical opinions as explained in § 404.1520c. * * *

* * * *

(3) *Consideration of other evidence.* Because symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. The information that your medical sources or nonmedical sources provide about your pain or other symptoms (e.g., what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the

intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptomrelated functional limitations and restrictions that your medical sources or nonmedical sources report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your medical sources, and observations by our employees and other persons. Section 404.1520c explains in detail how we consider medical opinions and prior administrative medical findings about the nature and severity of your impairment(s) and any related symptoms, such as pain. Factors relevant to your symptoms, such as pain, which we will consider include:

* * * *

(4) * * * We will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between your statements and the rest of the evidence, including your history, the signs and laboratory findings, and statements by your medical sources or other persons about how your symptoms affect you.

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IV.F.2. Evaluation of Symptoms in Disability Claims: SSR 16-3p

SSR 16-3p

Effective Date: March 28, 2016

POLICY INTERPRETATION RULING

Titles II and XVI: Evaluation of Symptoms in Disability Claims

This SSR supersedes [SSR 96-7p](#): Policy Interpretation Ruling Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements.

PURPOSE:

We are rescinding [SSR 96-7p](#): Policy Interpretation Ruling Titles II and XVI Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements and replacing it with this Ruling. We solicited a study and recommendations from the Administrative Conference of the United States (ACUS) on the topic of symptom evaluation. Based on ACUS's recommendations^[1] and our adjudicative experience, we are eliminating the use of the term "credibility" from our sub-regulatory policy, as our

regulations do not use this term. In doing so, we clarify that subjective symptom evaluation is not an examination of an individual's character. Instead, we will more closely follow our regulatory language regarding symptom evaluation.

Consistent with our regulations, we instruct our adjudicators to consider all of the evidence in an individual's record when they evaluate the intensity and persistence of symptoms after they find that the individual has a medically determinable impairment(s) that could reasonably be expected to produce those symptoms. We evaluate the intensity and persistence of an individual's symptoms so we can determine how symptoms limit ability to perform work-related activities for an adult and how symptoms limit ability to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim.

CITATIONS (AUTHORITY):

Sections [216\(i\)](#), [223\(d\)](#), and [1614\(a\)\(3\)](#) of the Social Security Act as amended; Regulations no. 4, sections [404.1508](#), [404.1512\(d\)](#), [404.1513](#), [404.1520](#), [404.1526](#), [404.1527](#), [404.1528](#), [404.1529](#), [404.1545](#) and [404.1594](#); and Regulations No. 16 sections [416.908](#), [416.912\(d\)](#), [416.913](#), [416.920](#), [416.924\(c\)](#), [416.924a\(b\)\(9\)\(ii-iii\)](#), [416.926a](#), [416.927](#), [416.928](#), [416.929](#), [416.930\(c\)](#), [416.945](#), [416.994](#), and [416.994a](#).

BACKGROUND:

In determining whether an individual is disabled, we consider all of the individual's symptoms, including pain, and the extent to which the symptoms can reasonably be accepted as consistent with the objective medical and other evidence in the individual's record. We define a symptom as the individual's own description or statement of his or her physical or mental impairment(s).^[2] Under our regulations, an individual's statements of symptoms alone are not enough to establish the existence of a physical or mental impairment or disability. However, if an individual alleges impairment-related symptoms, we must evaluate those symptoms using a two-step process set forth in our regulations.^[3]

First, we must consider whether there is an underlying medically determinable physical or mental impairment(s) that could reasonably be expected to produce an individual's symptoms, such as pain. Second, once an underlying physical or mental impairment(s) that could reasonably be expected to produce an individual's symptoms is established, we evaluate the intensity and persistence of those symptoms to determine the extent to which the symptoms limit an individual's ability to perform work-related activities for an adult or to function independently, appropriately, and effectively in an age- appropriate manner for a child with a title XVI disability claim.

This ruling clarifies how we consider:

- The intensity, persistence, and functionally limiting effects of symptoms,
- Objective medical evidence when evaluating symptoms,

- Other evidence when evaluating symptoms,
- The factors set forth in [20 CFR 404.1529\(c\)\(3\)](#) and [416.929\(c\)\(3\)](#),
- The extent to which an individual's symptoms affect his or her ability to perform work-related activities or function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim, and
- Adjudication standards for evaluating symptoms in the sequential evaluation process.

POLICY INTERPRETATION:

We use a two-step process for evaluating an individual's symptoms.

The two-step process:

Step 1: We determine whether the individual has a medically determinable impairment (MDI) that could reasonably be expected to produce the individual's alleged symptoms

An individual's symptoms, such as pain, fatigue, shortness of breath, weakness, nervousness, or periods of poor concentration will not be found to affect the ability to perform work-related activities for an adult or to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim unless medical signs or laboratory findings show a medically determinable impairment is present. Signs are anatomical, physiological, or psychological abnormalities established by medically acceptable clinical diagnostic techniques that can be observed apart from an individual's symptoms.^[4] Laboratory findings are anatomical, physiological, or psychological phenomena, which can be shown by the use of medically acceptable laboratory diagnostic techniques.^[5] We call the medical evidence that provides signs or laboratory findings objective medical evidence. We must have objective medical evidence from an acceptable medical source^[6] to establish the existence of a medically determinable impairment that could reasonably be expected to produce an individual's alleged symptoms.^[7]

In determining whether there is an underlying medically determinable impairment that could reasonably be expected to produce an individual's symptoms, we do not consider whether the severity of an individual's alleged symptoms is supported by the objective medical evidence. For example, if an individual has a medically determinable impairment established by a knee x-ray showing mild degenerative changes and he or she alleges extreme pain that limits his or her ability to stand and walk, we will find that individual has a medically determinable impairment that could reasonably be expected to produce the symptom of pain. We will proceed to step two of the two-step process, even though the level of pain an individual alleges may seem out of proportion with the objective medical evidence.

In some instances, the objective medical evidence clearly establishes that an individual's symptoms are due to a medically determinable impairment. At other times,

we may have insufficient evidence to determine whether an individual has a medically determinable impairment that could potentially account for his or her alleged symptoms. In those instances, we develop evidence regarding a potential medically determinable impairment using a variety of means set forth in our regulations. For example, we may obtain additional information from the individual about the nature of his or her symptoms and their effect on functioning. We may request additional information from the individual about other testing or treatment he or she may have undergone for the symptoms. We may request clarifying information from an individual's medical sources, or we may send an individual to a consultative examination that may include diagnostic testing. We may use our agency experts to help us determine whether an individual's medically determinable impairment could reasonably be expected to produce his or her symptoms. At the administrative law judge hearing level or the Appeals Council level of the administrative review process, we may ask for and consider evidence from a medical or psychological expert to help us determine whether an individual's medically determinable impairment could reasonably be expected to produce his or her symptoms. If an individual alleges symptoms, but the medical signs and laboratory findings do not substantiate any medically determinable impairment capable of producing the individual's alleged symptoms, we will not evaluate the individual's symptoms at step two of our two- step evaluation process.

We will not find an individual disabled based on alleged symptoms alone. If there is no medically determinable impairment, or if there is a medically determinable impairment, but the impairment(s) could not reasonably be expected to produce the individual's symptoms, we will not find those symptoms affect the ability to perform work-related activities for an adult or ability to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim.

Step 2: We evaluate the intensity and persistence of an individual's symptoms such as pain and determine the extent to which an individual's symptoms limit his or her ability to perform work-related activities for an adult or to function independently, appropriately, and effectively in an age- appropriate manner for a child with a title XVI disability claim.

Once the existence of a medically determinable impairment that could reasonably be expected to produce pain or other symptoms is established, we recognize that some individuals may experience symptoms differently and may be limited by symptoms to a greater or lesser extent than other individuals with the same medical impairments, the same objective medical evidence, and the same non-medical evidence. In considering the intensity, persistence, and limiting effects of an individual's symptoms, we examine the entire case record, including the objective medical evidence; an individual's statements about the intensity, persistence, and limiting effects of symptoms; statements and other information provided by medical sources and other persons; and any other relevant evidence in the individual's case record.

We will not evaluate an individual's symptoms without making every reasonable effort to obtain a complete medical history¹⁸ unless the evidence supports a finding that the individual is disabled. We will not evaluate an individual's symptoms based solely on

objective medical evidence unless that objective medical evidence supports a finding that the individual is disabled. We will evaluate an individual's symptoms based on the evidence in an individual's record as described below; however, not all of the types of evidence described below will be available or relevant in every case.

1. Consideration of Objective Medical Evidence

Symptoms cannot always be measured objectively through clinical or laboratory diagnostic techniques. However, objective medical evidence is a useful indicator to help make reasonable conclusions about the intensity and persistence of symptoms, including the effects those symptoms may have on the ability to perform work-related activities for an adult or to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI claim.^[9] We must consider whether an individual's statements about the intensity, persistence, and limiting effects of his or her symptoms are consistent with the medical signs and laboratory findings of record.

The intensity, persistence, and limiting effects of many symptoms can be clinically observed and recorded in the medical evidence. Examples such as reduced joint motion, muscle spasm, sensory deficit, and motor disruption illustrate findings that may result from, or be associated with, the symptom of pain.^[10] These findings may be consistent with an individual's statements about symptoms and their functional effects. However, when the results of tests are not consistent with other evidence in the record, they may be less supportive of an individual's statements about pain or other symptoms than test results and statements that are consistent with other evidence in the record.

For example, an individual with reduced muscle strength testing who indicates that for the last year pain has limited his or her standing and walking to no more than a few minutes a day would be expected to have some signs of muscle wasting as a result. If no muscle wasting were present, we might not, depending on the other evidence in the record, find the individual's reduced muscle strength on clinical testing to be consistent with the individual's alleged impairment-related symptoms.

However, we will not disregard an individual's statements about the intensity, persistence, and limiting effects of symptoms solely because the objective medical evidence does not substantiate the degree of impairment-related symptoms alleged by the individual.^[11] A report of minimal or negative findings or inconsistencies in the objective medical evidence is one of the many factors we must consider in evaluating the intensity, persistence, and limiting effects of an individual's symptoms.

2. Consideration of Other Evidence

If we cannot make a disability determination or decision that is fully favorable based solely on objective medical evidence, then we carefully consider other evidence in the record in reaching a conclusion about the intensity, persistence, and limiting effects of an individual's symptoms. Other evidence that we will consider includes statements from the individual, medical sources, and any other sources that might have information

about the individual's symptoms, including agency personnel, as well as the factors set forth in our regulations.^[12] For example, for a child with a title XVI disability claim, we will consider evidence submitted from educational agencies and personnel, statements from parents and other relatives, and evidence submitted by social welfare agencies, therapists, and other practitioners.^[13]

a. The Individual

An individual may make statements about the intensity, persistence, and limiting effects of his or her symptoms. If a child with a title XVI disability claim is unable to describe his or her symptoms adequately, we will accept a description of his or her symptoms from the person most familiar with the child, such as a parent, another relative, or a guardian.^[14] For an adult whose impairment prevents him or her from describing symptoms adequately, we may also consider a description of his or her symptoms from a person who is familiar with the individual.

An individual may make statements about symptoms directly to medical sources, other sources, or he or she may make them directly to us. An individual may have made statements about symptoms in connection with claims for other types of disability benefits such as workers' compensation, benefits under programs of the Department of Veterans Affairs, or private insurance benefits.

An individual's statements may address the frequency and duration of the symptoms, the location of the symptoms, and the impact of the symptoms on the ability to perform daily living activities. An individual's statements may also include activities that precipitate or aggravate the symptoms, medications and treatments used, and other methods used to alleviate the symptoms. We will consider an individual's statements about the intensity, persistence, and limiting effects of symptoms, and we will evaluate whether the statements are consistent with objective medical evidence and the other evidence.

b. Medical Sources

Medical sources may offer diagnoses, prognoses, and opinions as well as statements and medical reports about an individual's history, treatment, responses to treatment, prior work record, efforts to work, daily activities, and other information concerning the intensity, persistence, and limiting effects of an individual's symptoms.

Important information about symptoms recorded by medical sources and reported in the medical evidence may include, but is not limited to, the following:

- Onset, description of the character and location of the symptoms, precipitating and aggravating factors, frequency and duration, change over a period of time (e.g., whether worsening, improving, or static), and daily activities. Very often, the individual has provided this information to the medical source, and the information may be compared with the individual's other statements in the case record. In addition, the evidence provided by a medical source may contain

medical opinions about the individual's symptoms and their effects. Our adjudicators will weigh such opinions by applying the factors in [20 CFR 404.1527](#) and [416.927](#).

- A longitudinal record of any treatment and its success or failure, including any side effects of medication.
- Indications of other impairments, such as potential mental impairments, that could account for an individual's allegations.

Medical evidence from medical sources that have not treated or examined the individual is also important in the adjudicator's evaluation of an individual's statements about pain or other symptoms. For example, State agency medical and psychological consultants and other program physicians and psychologists may offer findings about the existence and severity of an individual's symptoms. We will consider these findings in evaluating the intensity, persistence, and limiting effects of the individual's symptoms. Adjudicators at the hearing level or at the Appeals Council level must consider the findings from these medical sources even though they are not bound by them. [\[15\]](#)

c. Non-Medical Sources

Other sources may provide information from which we may draw inferences and conclusions about an individual's statements that would be helpful to us in assessing the intensity, persistence, and limiting effects of symptoms. Examples of such sources include public and private agencies, other practitioners, educational personnel, non-medical sources such as family and friends, and agency personnel. We will consider any statements in the record noted by agency personnel who previously interviewed the individual, whether in person or by telephone. The adjudicator will consider any personal observations of the individual in terms of how consistent those observations are with the individual's statements about his or her symptoms as well as with all of the evidence in the file.

d. Factors to Consider in Evaluating the Intensity, Persistence, and Limiting Effects of an Individual's Symptoms

In addition to using all of the evidence to evaluate the intensity, persistence, and limiting effects of an individual's symptoms, we will also use the factors set forth in [20 CFR 404.1529\(c\)\(3\)](#) and [416.929\(c\)\(3\)](#). These factors include:

1. Daily activities;
2. The location, duration, frequency, and intensity of pain or other symptoms;
3. Factors that precipitate and aggravate the symptoms;
4. The type, dosage, effectiveness, and side effects of any medication an individual takes or has taken to alleviate pain or other symptoms;
5. Treatment, other than medication, an individual receives or has received for relief of pain or other symptoms;

6. Any measures other than treatment an individual uses or has used to relieve pain or other symptoms (e.g., lying flat on his or her back, standing for 15 to 20 minutes every hour, or sleeping on a board); and
7. Any other factors concerning an individual's functional limitations and restrictions due to pain or other symptoms.

We will consider other evidence to evaluate only the factors that are relevant to assessing the intensity, persistence, and limiting effects of the individual's symptoms. If there is no information in the evidence of record regarding one of the factors, we will not discuss that specific factor in the determination or decision because it is not relevant to the case. We will discuss the factors pertinent to the evidence of record.

How we will determine if an individual's symptoms affect the ability to perform work-related activities for an adult, or age-appropriate activities for a child with a title XVI disability claim

If an individual's statements about the intensity, persistence, and limiting effects of symptoms are consistent with the objective medical evidence and the other evidence of record, we will determine that the individual's symptoms are more likely to reduce his or her capacities to perform work-related activities for an adult or reduce a child's ability to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim.^[16] In contrast, if an individual's statements about the intensity, persistence, and limiting effects of symptoms are inconsistent with the objective medical evidence and the other evidence, we will determine that the individual's symptoms are less likely to reduce his or her capacities to perform work-related activities or abilities to function independently, appropriately, and effectively in an age-appropriate manner.

We may or may not find an individual's symptoms and related limitations consistent with the evidence in his or her record. We will explain which of an individual's symptoms we found consistent or inconsistent with the evidence in his or her record and how our evaluation of the individual's symptoms led to our conclusions. We will evaluate an individual's symptoms considering all the evidence in his or her record.

In determining whether an individual's symptoms will reduce his or her corresponding capacities to perform work-related activities or abilities to function independently, appropriately, and effectively in an age-appropriate manner, we will consider the consistency of the individual's own statements. To do so, we will compare statements an individual makes in connection with the individual's claim for disability benefits with any existing statements the individual made under other circumstances.

We will consider statements an individual made to us at each prior step of the administrative review process, as well as statements the individual made in any subsequent or prior disability claims under titles II and XVI. If an individual's various statements about the intensity, persistence, and limiting effects of symptoms are consistent with one another and consistent with the objective medical evidence and

other evidence in the record, we will determine that an individual's symptoms are more likely to reduce his or her capacities for work-related activities or reduce the abilities to function independently, appropriately, and effectively in an age- appropriate manner. However, inconsistencies in an individual's statements made at varying times does not necessarily mean they are inaccurate. Symptoms may vary in their intensity, persistence, and functional effects, or may worsen or improve with time. This may explain why an individual's statements vary when describing the intensity, persistence, or functional effects of symptoms.

We will consider an individual's attempts to seek medical treatment for symptoms and to follow treatment once it is prescribed when evaluating whether symptom intensity and persistence affect the ability to perform work-related activities for an adult or the ability to function independently, appropriately, and effectively in an age- appropriate manner for a child with a title XVI disability claim. Persistent attempts to obtain relief of symptoms, such as increasing dosages and changing medications, trying a variety of treatments, referrals to specialists, or changing treatment sources may be an indication that an individual's symptoms are a source of distress and may show that they are intense and persistent.[\[17\]](#)

In contrast, if the frequency or extent of the treatment sought by an individual is not comparable with the degree of the individual's subjective complaints, or if the individual fails to follow prescribed treatment that might improve symptoms, we may find the alleged intensity and persistence of an individual's symptoms are inconsistent with the overall evidence of record. We will not find an individual's symptoms inconsistent with the evidence in the record on this basis without considering possible reasons he or she may not comply with treatment or seek treatment consistent with the degree of his or her complaints. We may need to contact the individual regarding the lack of treatment or, at an administrative proceeding, ask why he or she has not complied with or sought treatment in a manner consistent with his or her complaints. When we consider the individual's treatment history, we may consider (but are not limited to) one or more of the following:

- An individual may have structured his or her activities to minimize symptoms to a tolerable level by avoiding physical activities or mental stressors that aggravate his or her symptoms.
- An individual may receive periodic treatment or evaluation for refills of medications because his or her symptoms have reached a plateau.
- An individual may not agree to take prescription medications because the side effects are less tolerable than the symptoms.
- An individual may not be able to afford treatment and may not have access to free or low-cost medical services.
- A medical source may have advised the individual that there is no further effective treatment to prescribe or recommend that would benefit the individual.
- An individual's symptoms may not be severe enough to prompt him or her to seek treatment, or the symptoms may be relieved with over the counter medications.

- An individual's religious beliefs may prohibit prescribed treatment.
- Due to various limitations (such as language or mental limitations), an individual may not understand the appropriate treatment for or the need for consistent treatment of his or her impairment.
- Due to a mental impairment (for example, individuals with mental impairments that affect judgment, reality testing, or orientation), an individual may not be aware that he or she has a disorder that requires treatment.
- A child may disregard the level and frequency of treatment needed to maintain or improve functioning because it interferes with his or her participation in activities typical of other children his or her age without impairments.

The above examples illustrate possible reasons an individual may not have pursued treatment. However, we will consider and address reasons for not pursuing treatment that are pertinent to an individual's case. We will review the case record to determine whether there are explanations for inconsistencies in the individual's statements about symptoms and their effects, and whether the evidence of record supports any of the individual's statements at the time he or she made them. We will explain how we considered the individual's reasons in our evaluation of the individual's symptoms.

Adjudication - How we will use our evaluation of symptoms in our five-step sequential evaluation process to determine whether an individual is disabled

In evaluating an individual's symptoms, it is not sufficient for our adjudicators to make a single, conclusory statement that "the individual's statements about his or her symptoms have been considered" or that "the statements about the individual's symptoms are (or are not) supported or consistent." It is also not enough for our adjudicators simply to recite the factors described in the regulations for evaluating symptoms. The determination or decision must contain specific reasons for the weight given to the individual's symptoms, be consistent with and supported by the evidence, and be clearly articulated so the individual and any subsequent reviewer can assess how the adjudicator evaluated the individual's symptoms.

Our adjudicators must base their findings solely on the evidence in the case record, including any testimony from the individual or other witnesses at a hearing before an administrative law judge or hearing officer. The subjective statements of the individual and witnesses obtained at a hearing should directly relate to symptoms the individual alleged. Our adjudicators are prohibited from soliciting additional non-medical evidence outside of the record on their own, except as set forth in our regulations and policies.

Adjudicators must limit their evaluation to the individual's statements about his or her symptoms and the evidence in the record that is relevant to the individual's impairments. In evaluating an individual's symptoms, our adjudicators will not assess an individual's overall character or truthfulness in the manner typically used during an adversarial court litigation. The focus of the evaluation of an individual's symptoms should not be to determine whether he or she is a truthful person. Rather, our adjudicators will focus on

whether the evidence establishes a medically determinable impairment that could reasonably be expected to produce the individual's symptoms and given the adjudicator's evaluation of the individual's symptoms, whether the intensity and persistence of the symptoms limit the individual's ability to perform work-related activities or, for a child with a title XVI disability claim, limit the child's ability to function independently, appropriately, and effectively in an age-appropriate manner.

In determining whether an individual is disabled or continues to be disabled, our adjudicators follow a sequential evaluation process.^[18] The first step of our five-step sequential evaluation process considers whether an individual is performing substantial gainful activity. If the individual is performing substantial gainful activity, we find him or her not disabled. If the individual is not performing substantial gainful activity, we proceed to step 2. We do not consider symptoms at the first step of the sequential evaluation process.

At step 2 of the sequential evaluation process, we determine whether an individual has a severe medically determinable physical or mental impairment or combination of impairments that has lasted or can be expected to last for a continuous period of at least 12 months or end in death.^[19] A severe impairment is one that affects an individual's ability to perform basic work-related activities for an adult or that causes more than minimal functional limitations for a child with a title XVI disability claim.^[20] At this step, we will consider an individual's symptoms and functional limitations to determine whether his or her impairment(s) is severe unless the objective medical evidence alone establishes a severe medically determinable impairment or combination of impairments that meets our duration requirement.^[21] If an individual does not have a severe medically determinable impairment that meets our duration requirement, we will find the individual not disabled at step 2. If the individual has a severe medically determinable impairment that has met or is expected to meet our duration requirement, we proceed to the next step.

At step 3 of the sequential evaluation process, we determine whether an individual's impairment(s) meets or medically equals the severity requirements of a listed impairment. To decide whether the impairment meets the level of severity described in a listed impairment, we will consider an individual's symptoms when a symptom(s) is one of the criteria in a listing to ensure the symptom is present in combination with the other criteria. If the symptom is not one of the criteria in a listing, we will not evaluate an individual's symptoms at this step as long as all other findings required by the specific listing are present. Unless the listing states otherwise, it is not necessary to provide information about the intensity, persistence, or limiting effects of a symptom as long as all other findings required by the specific listing are present.^[22] In considering whether an individual's symptoms, signs, and laboratory findings are medically equal to the symptoms, signs, and laboratory findings of a listed impairment, we will look to see whether the symptoms, signs, and laboratory findings are at least equal in severity to the listed criteria. However, we will not substitute the individual's allegations of pain or other symptoms for a missing or deficient sign or laboratory finding to raise the severity of the impairment(s) to that of a listed impairment.^[23] If an individual's impairment meets

or medically equals the severity requirements of a listing, we find him or her disabled. If an individual's impairment does not meet or medically equal a listing, we proceed to assess the individual's residual functional capacity at step 4 of the sequential evaluation process unless the individual is a child with a title XVI disability claim.

For a child with a title XVI disability claim whose impairment does not meet or medically equal the severity requirements of a listing, we consider whether his or her impairment functionally equals the listings. This means that the impairment results in "marked" limitations in two out of six domains of functioning or an "extreme" limitation in one of the six domains.^[24] We will evaluate an individual's symptoms at this step when we rate how a child's impairment-related symptoms affect his or her ability to function independently, appropriately, and effectively in an age-appropriate manner in each functional domain. If a child's impairment functionally equals a listing, we find him or her disabled. If a child's impairment does not functionally equal the listings, we find him or her not disabled. For a child with a title XVI disability claim, the sequential evaluation process ends at this step.

If the individual's impairment does not meet or equal a listing, we will assess and make a finding about an individual's residual functional capacity based on all the relevant medical and other evidence in the individual's case record. An individual's residual functional capacity is the most the individual can still do despite his or her impairment-related limitations. We consider the individual's symptoms when determining his or her residual functional capacity and the extent to which the individual's impairment-related symptoms are consistent with the evidence in the record.^[25]

After establishing the residual functional capacity, we determine whether an individual is able to do any past relevant work. At step 4, we compare the individual's residual functional capacity with the requirements of his or her past relevant work. If the individual's residual functional capacity is consistent with the demands of any of his or her past relevant work, either as the individual performed it or as the occupation is generally performed in the national economy, then we will find the individual not disabled. If none of the individual's past relevant work is within his or her residual functional capacity, we proceed to step 5 of the sequential evaluation process.

At step 5 of the sequential evaluation process, we determine whether the individual is able to adjust to other work that exists in significant numbers in the national economy. We consider the same residual functional capacity, together with the individual's age, education, and past work experience. If the individual is able to adjust to other work that exists in significant numbers in the national economy, we will find him or her not disabled. If the individual cannot adjust to other work that exists in significant numbers in the national economy, we find him or her disabled. At step 5 of the sequential evaluation process, we will not consider an individual's symptoms any further because we considered the individual's symptoms when we determined the individual's residual functional capacity.

EFFECTIVE DATE: This SSR is effective on March 28, 2016

CROSS-REFERENCES: [SSR 96-3p](#), “Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment is Severe,” [SSR 96-8p](#), “Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims,” [SSR 96-6p](#), “Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence;” and Program Operations Manual System, sections [DI 24515.061](#) and [DI 24515.064](#).

[1] ACUS made several recommendations in its March 12, 2015 final report, “Evaluating Subjective Symptoms in Disability Claims.” Among other things, ACUS recommended we consider amending [SSR 96-7p](#) to clarify that subjective symptom evaluation is not an examination of an individual's character, but rather is an evidence-based analysis of the administrative record to determine whether the nature, intensity, frequency, or severity of an individual's symptoms impact his or her ability to work. In any revised SSR, ACUS also recommended we more closely follow our regulatory language about symptom evaluation, which does not use the term “credibility” and instead directs adjudicators to consider medical and other evidence to evaluate the intensity and persistence of symptoms to determine how the individual's symptoms limit capacity for work if he or she is an adult, or for a child with a title XVI disability claim, how symptoms limit ability to function. ACUS further recommended when revising [SSR 96-7p](#), we offer additional guidance to adjudicators on regulatory implementation problems that have been identified since we published [SSR 96-7p](#).

[2] See [20 CFR 404.1528\(a\)](#) and [416.928\(a\)](#) for how our regulations define symptoms.

[3] See [20 CFR 404.1529](#) and [416.929](#) for how we evaluate statements of symptoms.

[4] See [20 CFR 404.1528\(b\)](#) and [416.928\(b\)](#) for how our regulations define signs.

[5] See [20 CFR 404.1528\(c\)](#) and [416.928\(c\)](#) for how our regulations define laboratory findings.

[6] See [20 CFR 404.1513\(a\)](#) and [416.913\(a\)](#) for a list of acceptable medical sources.

[7] See [20 CFR 404.1508](#) and [416.908](#) for what is needed to show a medically determinable impairment.

[8] By “complete medical history,” we mean the individual's complete medical history for at least the 12 months preceding the month in which he or she filed an application, unless there is a reason to believe that development of an earlier period is necessary or the individual says that his or her alleged disability began less than 12 months before he or she filed an application. [20 CFR 404.1512\(d\)](#) and [416.912\(d\)](#).

[9] See [20 CFR 404.1529\(c\)\(2\)](#) and [416.929\(c\)\(2\)](#).

[10] See [20 CFR 404.1529\(c\)\(2\)](#) and [416.929\(c\)\(2\)](#).

- [11] See [20 CFR 404.1529](#) and [416.929](#).
- [12] See [20 CFR 404.1513](#) and [416.913](#).
- [13] See [20 CFR 404.1529\(c\)\(3\)](#) and [416.929\(c\)\(3\)](#)
- [14] See [20 CFR 416.928\(a\)](#).
- [15] See [20 CFR 404.1527](#) and [416.927](#).
- [16] See [20 CFR 404.1529\(c\)\(4\)](#) and [416.929\(c\)\(4\)](#).
- [17] See [20 CFR 404.1529\(c\)](#) and [416.929\(c\)](#).
- [18] See [20 CFR 404.1520](#) and [416.920](#). For continuing disability, see 404.1594, [416.994](#) and [416.994a](#).
- [19] See [20 CFR 404.1520\(a\)\(4\)\(ii\)](#) and [416.920\(a\)\(4\)\(ii\)](#).
- [20] See [20 CFR 416.924\(c\)](#).
- [21] See [20 CFR 416.920\(c\)](#) for adults and [416.924\(c\)](#) for children.
- [22] See [20 CFR 404.1529\(d\)\(2\)](#) and [416.929\(d\)\(2\)](#).
- [23] See [20 CFR 404.1529\(d\)\(3\)](#) and [416.929\(d\)\(3\)](#).
- [24] See [20 CFR 416.926a](#).
- [25] See [20 CFR 404.1545](#) and [416.945](#).

IV.F.3. Evaluation of Symptoms - Desk Guide

EVALUATING SYMPTOMS – DESK GUIDE

SSR 16-3p and 20 CFR [404.1529](#) and [416.929](#)

Mandated TWO-STEP Process for Evaluating Symptoms		
Step	Conclusion	Next Action
STEP ONE: <i>Is there a medically determinable impairment (MDI) that could reasonably cause the claimant's alleged symptoms?</i>	Yes	Proceed to Step Two
	No	Do not evaluate any symptom that you cannot reasonably attribute to the claimant's MDI(s) at any step of sequential evaluation.
STEP TWO: Evaluate the intensity and persistence of those symptoms to determine the extent to which the symptoms limit the claimant's ability to perform work-related activities for an adult or to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim. <i>Are the symptoms consistent with the objective medical evidence alone?</i>	Yes	No further symptom evaluation is necessary. If alleged symptoms and resulting limitations are consistent with the objective medical evidence, the claimant's alleged limitations incorporate the alleged symptoms and resulting limitations into the RFC.
	No	Evaluate the consistency of the claimant's alleged symptoms with all of the evidence in the case file. Consider the symptom evaluation factors that are pertinent to the claimant's case.

FACTORS CONSIDERED IN A SYMPTOMS EVALUATION

Consider all of the evidence to evaluate the intensity, persistence, and limiting effects of an individual's symptoms. Consider each of the following factors if relevant to the claim:

- *Daily activities;*
- *The location, duration, frequency, and intensity of pain or other symptoms;*

- *Factors that precipitate and aggravate the symptoms;*
- *The type, dosage, effectiveness, and side effects of any medication an individual takes or has taken to alleviate pain or other symptoms;*
- *Treatment, other than medication, an individual receives or has received for relief of pain or other symptoms;*
- *Any measures other than treatment an individual uses or has used to relieve pain or other symptoms (e.g., lying flat on his or her back, standing for 15 to 20 minutes every hour, or sleeping on a board): and*
- *Any other factors concerning an individual's functional limitations and restrictions due to pain or other symptoms.*

General Guidelines for Evaluating Symptoms

- A symptom evaluation may be necessary at step 2 of sequential evaluation if the claimant has an MDI, but the objective medical evidence does not support a severe impairment, while the claimant's MDI-related alleged symptoms and resulting limitations suggest his or her impairment is severe.
- A symptom evaluation may be necessary at step 3 of sequential evaluation if the listing(s) under consideration includes symptoms.
- A symptom evaluation may be necessary when assessing an RFC if the claimant's symptoms and resulting limitations can reasonably be linked to an MDI and his or her alleged symptoms and resulting limitations are NOT consistent with the objective medical evidence alone. If the claimant's MDI-related symptoms and resulting limitations are consistent with the objective medical evidence, incorporate the symptom-related limitations into the RFC.
- We will never find a claimant disabled based on his or her alleged symptoms alone.
- We will never find a claimant not disabled because his or her symptoms are not consistent with the objective medical evidence without evaluating the claimant's symptoms based on all of the evidence in the file and a consideration of the factors in 20 CFR 404.1529(c)(3) and 416.929(c)(3) that are relevant to the case.
- If any of the claimant's alleged symptoms and resulting limitations are consistent with the objective medical evidence alone, or are found consistent with all of the evidence in the case file after a symptoms evaluation, and we are assessing an RFC, the RFC will include any of the claimant's alleged limitations that are consistent with the objective medical evidence alone, or are found consistent with all of the evidence in the case file after a symptoms evaluation.
- We will consider a claimant's persistent attempts to obtain relief of symptoms such as increasing dosages and changing medications, trying a variety of treatments, referrals to specialists, or changing treatment sources to be an indication that the symptoms are a source of distress and are intense and persistent.
- If the frequency or extent of the treatment sought by a claimant is not comparable with the degree of claimant's alleged symptoms, we will not find his or her symptoms inconsistent with the evidence in file without considering possible reasons he or she may not have sought treatment in a manner consistent with his or her alleged symptoms.
- A symptom evaluation may be necessary at step 2 of sequential evaluation if the claimant has an MDI, but the objective medical evidence does not support a severe impairment, while the claimant's MDI-related alleged symptoms and resulting limitations suggest his or her impairment is severe.

- A symptom evaluation may be necessary at step 3 of sequential evaluation if the listing(s) under consideration includes symptoms.
 - A symptom evaluation may be necessary when assessing an RFC if the claimant's symptoms and resulting limitations can reasonably be linked to an MDI and his or her alleged symptoms and resulting limitations are NOT consistent with the objective medical evidence alone. If the claimant's MDI-related symptoms and resulting limitations are consistent with the objective medical evidence, incorporate the symptom-related limitations into the RFC.
 - We will never find a claimant disabled based on his or her alleged symptoms alone.
 - We will never find a claimant not disabled because his or her symptoms are not consistent with the objective medical evidence without evaluating the claimant's symptoms based on all of the evidence in the file and a consideration of the factors in 20 CFR 404.1529(c)(3) and 416.929(c)(3) that are relevant to the case.
 - If any of the claimant's alleged symptoms and resulting limitations are consistent with the objective medical evidence alone, or are found consistent with all of the evidence in the case file after a symptoms evaluation, and we are assessing an RFC, the RFC will include any of the claimant's alleged limitations that are consistent with the objective medical evidence alone, or are found consistent with all of the evidence in the case file after a symptoms evaluation.
 - We will consider a claimant's persistent attempts to obtain relief of symptoms such as increasing dosages and changing medications, trying a variety of treatments, referrals to specialists, or changing treatment sources to be an indication that the symptoms are a source of distress and are intense and persistent.
 - If the frequency or extent of the treatment sought by a claimant is not comparable with the degree of claimant's alleged symptoms, we will not find his or her symptoms inconsistent with the evidence in file without considering possible reasons he or she may not have sought treatment in a manner consistent with his or her alleged symptoms.
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IV.F.4. Adjudication Tip #52 – Evaluating the Functional Limitations of Pain

#52

We all know that symptoms such as pain may be found to affect an individual's ability to do basic work activities if there is a medically determinable impairment that could reasonably be expected to produce the alleged symptoms. But did you know that an individual's symptoms, including pain, can cause limitations or restrictions that are classified as exertional, nonexertional, or a combination of both (see 20 CFR 404.1569a, 416.969a, and SSR 96-4p)?

For example, pain caused by a physical impairment can cause nonexertional limitations including manipulative limitations (e.g., reaching, handling) and/or mental limitations (e.g., understanding and remembering instructions). Similarly, although mental impairments usually affect only nonexertional functions, they might also limit exertional capacity. For example, a mental impairment might cause pain, fatigue or hysterical paralysis with resulting difficulty walking or standing. Therefore, symptoms including pain, are not intrinsically exertional or nonexertional; it is the functional limitations that a symptom causes that can be exertional, nonexertional, or both (SSR 96-4p).

As with other findings in the decision, the residual functional capacity (RFC) assessment must include a narrative discussion describing how the evidence supports each conclusion. While pain can lead to mental limitations, these limitations must always be clearly established by the evidence and explained thoroughly in the decision. Without this documented explanation, key findings, including the inability to perform skilled past relevant work, no transferable skills, or erosion of the occupational base, may not be supported by substantial evidence. We must look to the record for corroborating evidence (e.g., medication side effects, clinical observations, daily activities, opinion evidence, claimant's statements, third party statements, and all other relevant evidence). Ultimately, the decision must clearly articulate the rationale and make the direct link between the impairment (e.g., degenerative disc disease), the symptom (e.g., pain), and the RFC. The key is comprehensive, clear, and consistent articulation.

For additional information, see Social Security Rulings 96-3p, 96-4p, 96-7p, 96-8p, 03-01p, and 03-02p; Appeals Council Feedback Training: Symptom Evaluation, and Appeals Council Feedback Training: Evaluating Allegations of Mental Impairments.

IV.F.5. MENTAL IMPAIRMENTS

IV.F.5.a. 12.00 Mental Disorders -- Adult

<https://www.ssa.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm>

IV.F.5.b. 112.00 Mental Disorders -- Childhood

<https://www.ssa.gov/disability/professionals/bluebook/112.00-MentalDisorders-Childhood.htm>

IV.F.5.b. TITLES II AND XVI: CAPACITY TO DO OTHER WORK – THE MEDICAL-VOCATIONAL RULES AS A FRAMEWORK FOR EVALUATING SOLELY NONEXERTIONAL IMPAIRMENTS: SSR 85-15

SSR 85-15

This supersedes Program Policy Statement No. 116 (SSR 85-7) with the same title (which superseded Program Policy Statement No. 104 (SSR 83-13) and is in accord with an order of the U.S. District Court for the District of Minnesota.

PURPOSE:

The original purpose of SSR 83-13 was to clarify how the regulations and the exertionally based numbered decisional rules in Appendix 2, Subpart P, Regulations No. 4, provide a framework for decisions concerning persons who have only a nonexertional limitation(s) of function or an environmental restriction(s). The purpose of this revision to SSR 83-13 and SSR 85-7 is to emphasize, in the sections relating to mental impairments: (1) that the potential job base for mentally ill claimants without adverse vocational factors is not necessarily large even for individuals who have no other impairments, unless their remaining mental capacities are sufficient to meet the intellectual and emotional demands of at least unskilled, competitive, remunerative work on a sustained basis; and (2) that a finding of disability can be appropriate for an individual who has a severe mental impairment which does not meet or equal the Listing of Impairments, even where he or she does not have adversities in age, education, or work experience.

CITATIONS (AUTHORITY):

Sections 223(d)(2)(A) and 1614(a)(3)(E) of the Social Security Act; Regulations No. 4, Subpart P, sections 404.1505(a), 404.1520(f)(1), 404.1521(b), 404.1545, and 404.1560 through 404.1569; Appendix 2 of Subpart P, sections 200.00(c), 200.00(e)(1), and 204.00; and Regulations No. 16, Subpart 1, sections 416.905(a), 416.920(f)(1), 416.921(b), 416.945, and 416.960 through 416.969.

PERTINENT HISTORY:

If a person has a severe medically determinable impairment which, though not meeting or equaling the criteria in the Listing of Impairments, prevents the person from doing past relevant work, it must be determined whether the person can do other work. This involves consideration of the person's RFC and the vocational factors of age, education, and work experience.

The Medical-Vocational Guidelines (Regulations No. 4, Subpart P, Appendix 2) discuss the relative adjudicative weights which are assigned to a person's age, education, and work experience. Three tables in Appendix 2 illustrate the interaction of these vocational factors with his or her RFC. RFC is expressed in terms of sedentary, light, and medium work exertion. The tables rules reflect the potential occupational base of unskilled jobs for individuals who have severe impairments which limit their exertional capacities: approximately 2,500 medium, light, and sedentary occupations; 1,600 light and sedentary occupations; and 200 sedentary occupations — each occupation representing numerous jobs in the national economy. (See the text and glossary in [SSR 83-10](#), PPS-101, Determining Capability to Do Other Work — the Medical-Vocational Rules of Appendix 2.) Where individuals also have nonexertional limitations of function or environmental restrictions, the table rules provide a framework for consideration of how much the individual's work capability is further diminished in terms of any types of jobs within these exertional ranges with would be contraindicated by the additional limitations or restrictions. However, where a person has solely a nonexertional impairment(s), the tables rules do not direct conclusions of disabled or not disabled.

Conclusions must, instead, be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2.

This PPS clarifies policies applicable in cases involving the evaluation of solely nonexertional impairments.

POLICY STATEMENT:

Given that no medically determinable impairment limits exertion, the RFC reflecting the severity of the particular nonexertional impairment(s) with its limiting effects on the broad world of work is the first issue. The individual's relative advantages or adversities in terms of age, education, and work experience is the second. Section 204.00 of Appendix 2 provides an example of one type of nonexertional impairment — environmental restrictions — and states that environmental restrictions ordinarily would not significantly affect the range of work existing in the national economy for individuals with the physical capability for heavy work (or very heavy work); i.e., with no medically determinable impairment which limits exertion. However, numerous environmental restrictions might lead to a different conclusion, as might one or more severe losses of nonexertional functional capacities. The medical and vocational factors of the individual case determine whether exclusion of particular occupation or kinds of work so reduces the person's vocational opportunity that a work adjustment could not be made.

Nonexertional Impairments Contrasted with Exertional Impairments

The term "exertional" has the same meaning in the regulations as it has in the U.S. Department of Labor's classifications of occupations by strength levels. (See [SSR 83-10](#), PPS-101, Determining Capability to Do Other Work — The Medical-Vocational Rules of Appendix 2.) Any job requirement which is not exertional is considered to be nonexertional. A nonexertional impairment is one which is medically determinable and causes a nonexertional limitation of function or an environmental restriction. Nonexertional impairments may or may not affect a person's capacity to carry out the primary strength requirements of jobs, and they may or may not significantly narrow the range of work a person can do.

Nonexertional limitations can affect the abilities to reach; to seize, hold, grasp, or turn an object (handle); to bend the legs alone (kneel); to bend the spine alone (stoop) or bend both the spine and legs (crouch). Fine movements of small objects, such as done in much sedentary work and in certain types of more demanding work (e.g., surgery), require use of the fingers to pick, pinch, etc. Impairments of vision, speech, and hearing are nonexertional. Mental impairments are generally considered to be nonexertional, but depressions and conversion disorders may limit exertion. Although some impairments may cause both exertional limitations and environmental restriction (e.g., a respiratory impairment may limit a person to light work exertion as well as contraindicate exposure to excessive dust or fumes), other impairments may result in only environmental restrictions (e.g., skin allergies may only contraindicate contact with certain liquids).

What is a nonexertional and extremely rare factor in one range of work (e.g., crawling in sedentary work) may become an important element in arduous work like coal mining.

Where a person's exertional capacity is compromised by a nonexertional impairment(s), see [SSR 83-14](#), PPS-105, Capability to Do Other Work — The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments.

Jobs which can possibly be performed by persons with solely nonexertional impairments are not limited to the approximately 2,500 unskilled sedentary, light and medium occupations which pertain to the table rules in Appendix 2. The occupational base cuts across exertional categories through heavy (and very heavy) work and will include occupations above the unskilled level if a person has skills transferable to skilled and semiskilled occupations within his or her RFC. (Note the examples in item 4.b of [SSR 82-41](#), PPS-67, Work Skills and Their Transferability as Intended by the Expanded Vocational Factors Regulations effective February 26, 1979, where medical factors prevent not only the performance of past work but also the transferability of skills.)

Given no medically determinable impairment which limits exertion, the first issue is how much the person's occupational base — the entire exertional span from sedentary work through heavy (or very heavy) work — is reduced by the effects of the nonexertional impairment(s). This may range from very little to very much, depending on the nature and extent of the impairment(s). In many cases, a decisionmaker will need to consult a vocational resource.

The publications listed in sections 404.1566 and 416.966 of the regulations will be sufficient vocational resources for relatively simple issues. In more complex cases, a person or persons with specialized knowledge would be helpful. State agencies may use personnel termed vocational consultants or specialist, or they may purchase the services of vocational evaluation workshops. Vocational experts may testify for this purpose at the hearing and appeals levels. In this PPS, the term vocational specialist (VS) describes all vocational resource personnel.

The second issue is whether the person can be expected to make a vocational adjustment considering the interaction of his or her remaining occupational base with his or her age, education, and work experience. A decisionmaker must consider sections 404.1562-404.1568 and 416.962-416.968 of the regulations, section 204.00 of Appendix 2, and the table rules for specific case situations in Appendix 2. If, despite the nonexertional impairment(s), an individual has a large potential occupational base, he or she would ordinarily not be found disabled in the absence of extreme adversities in age, education, and work experience. (This principle is illustrated in rule 203.01, 203.02, and 203.10 and is set out in [SSR 82-63](#), PPS-79, Medical-Vocational Profiles Showing an Inability to Make an Adjustment to Other Work.) The assistance of a vocational resource may be helpful. Whenever vocational resources are used and in the decision is adverse to the claimant, the determination or decision will include: (1) citations of examples of occupation/jobs the person can do functionally and vocationally, and (2) a statement of

the incidence of such work in the region in which the individual resides or in several regions of the country.

*Examples of Nonexertional Impairments
and Their Effects on the Occupational Base*

1. Mental Impairments

There has been some misunderstanding in the evaluation of mental impairments. Unless the claimant or beneficiary is a widow, widower, surviving divorced spouse or a disabled child under the Supplemental Security Income program, the sequential evaluation process mandated by the regulations does not end with the finding that the impairment, though severe, does not meet or equal an impairment listed in Appendix 1 of the regulations. The process must go on to consider whether the individual can meet the mental demands of past relevant work in spite of the limiting effects of his or her impairment and, if not, whether the person can do other work, considering his or her remaining mental capacities reflected in terms of the occupational base, age, education, and work experience. The decisionmaker must not assume that failure to meet or equal a listed mental impairment equates with capacity to do at least unskilled work. The decision requires careful consideration of the assessment of RFC.

In the world of work, losses of intellectual and emotional capacities are generally more serious when the job is complex. Mental impairments may or may not prevent the performance of a person's past jobs. They may or may not prevent an individual from transferring work skills. (See [SSR 82-41](#), PPS-67, Work Skills and Their Transferability as Intended by the Expanded Vocational Factors Regulations effective February 26, 1979.)

Where a person's only impairment is mental, is not of listing severity, but does prevent the person from meeting the mental demands of past relevant work and prevents the transferability of acquired work skills, the final consideration is whether the person can be expected to perform unskilled work. The basic mental demands of competitive, remunerative, unskilled work include the abilities (on a sustained basis) to understand, carry out, and remember simple instructions; to respond appropriately to supervision, coworkers, and usual work situations; and to deal with changes in a routine work setting. A substantial loss of ability to meet any of these basic work-related activities would severely limit the potential occupational base. This, in turn, would justify a finding of disability because even favorable age, education, or work experience will not offset such a severely limited occupational base.

Example 1: A person whose vocational factors of age, education, and work experience would ordinarily be considered favorable (i.e., very young age, university education, and highly skilled work experience) would have severely limited occupational base if he or she has a mental impairment which causes a substantial loss of ability to respond appropriately to supervision, coworkers, and usual work situations. A finding of disability would be appropriate.

Where there is no exertional impairment, unskilled jobs at all levels of exertion constitute the potential occupational base for persons who can meet the mental demands of unskilled work. These jobs ordinarily involve dealing primarily with objects, rather than with data or people, and they generally provide substantial vocational opportunity for person with solely mental impairments who retain the capacity to meet the intellectual and emotional demands of such jobs on a sustained basis. However, persons with this large job base may be found disabled because of adversities in age, education, and work experience. (This is illustrated in examples 2 and 3 immediately following.)

Example 2: Someone who is of advanced age, has a limited education, has no relevant work experience, and has more than a non severe mental impairment will generally be found disabled. (See [SSR 82-63](#), PPS-79, Medical-Vocational Profiles Showing an Inability to Make an Adjustment to Other Work.)

Example 3: Someone who is closely approaching retirement age, has a limited education or less, worked for 30 years in a cafeteria doing an unskilled job as a "server," almost constantly dealing with the public, and now cannot, because of a severe mental impairment, frequently deal with the public. In light of the narrowed vocational opportunity in conjunction with the person's age, education, lack of skills, and long commitment to the particular type of work, a finding of disabled would be appropriate; but the decision would not necessarily be the same for a younger, better-educated, or skilled person. (Compare sections 404.1562 and 416.962 of the regulations and rule 203.01 of Appendix 2.)

Where a person has only a mental impairment but does not have extreme adversities in age, education, and work experience, and does not lack the capacity to do basic work-related activities, the potential occupational base would be reduced by his or her inability to perform certain complexities or particular kinds of work. These limitations would affect the occupational base in various ways.

Example 4: Someone who is of advance age, has a high school education, and did skilled work as manager of a housing project can no longer, because of a severe mental impairment, develop and implement plans and procedures, prepare budget requests, schedule repairs or otherwise deal with complexities of this level and nature. Assuming that, in this case, all types of related skilled jobs are precluded but the individual can do work which is not detailed and does not require lengthy planning, the remaining related semiskilled jobs to which skills can be transferred and varied unskilled jobs, at all levels of exertion, constitute a significant vocational opportunity. A conclusion of "not disabled" would be appropriate. (Compare rules 201.07, 202.07, and 203.13 of Appendix 2.)

Example 5: Someone who is of advanced age, has a limited education, and did semiskilled work as a first-aid attendant no longer has the mental capacity to work with

people who are in emergency situations and require immediate attention to cuts, burns, suffocation, etc. Although there may be very few related semiskilled occupations to which this person could transfer work skills, the large occupational base of unskilled work at all levels of exertion generally would justify a finding of not under a disability. (This is consistent with rules 203.11-203.17 of Appendix 2.)

Stress and Mental Illness — Since mental illness is defined and characterized by maladaptive behavior, it is not unusual that the mentally impaired have difficulty accommodating to the demands of work and work-like settings. Determining whether these individuals will be able to adapt to the demands or "stress" of the workplace is often extremely difficult. This section is not intended to set out any presumptive limitations for disorders, but to emphasize the importance of thoroughness in evaluation on an individualized basis.

Individuals with mental disorders often adopt a highly restricted and/or inflexible lifestyle within which they appear to function well. Good mental health services and care may enable chronic patients to function adequately in the community by lowering psychological pressures, by medication, and by support from services such as outpatient facilities, day care programs, social work programs and similar assistance.

The reaction to the demands of work (stress) is highly individualized, and mental illness is characterized by adverse responses to seemingly trivial circumstances. The mentally impaired may cease to function effectively when facing such demands as getting to work regularly, having their performance supervised, and remaining in the workplace for a full day. A person may become panicked and develop palpitations, shortness of breath, or feel faint while riding in an elevator; another may experience terror and begin to hallucinate when approached by a stranger asking a question. Thus, the mentally impaired may have difficulty meeting the requirement of even so-called "low stress" jobs.

Because response to the demands of work is highly individualized, the skill level of a position is not necessarily related to the difficulty an individual will have in meeting the demands of the job. A claimant's condition may make performance of an unskilled job as difficult as an objectively more demanding job, for example, a busboy need only clear dishes from tables. But an individual with a severe mental disorder may find unmanageable the demand of making sure that he removes all the dishes, does not drop them, and gets the table cleared promptly for the waiter or waitress. Similarly, an individual who cannot tolerate being supervised may be not able to work even in the absence of close supervision; the *knowledge* that one's work is being judged and evaluated, even when the supervision is remote or indirect, can be intolerated for some mentally impaired persons. Any impairment-related limitations created by an individual's response to demands of work, however, must be reflected in the RFC assessment.

2. Postural-Manipulative Impairments

a. Limitations in *climbing and balancing* can have varying effects on the occupational base, depending on the degree of limitation and the type of job. Usual everyday activities, both at home and at work, include ascending or descending ramps or a few stairs and maintaining body equilibrium while doing so. These activities are required more in some jobs than in others, and they may be critical in some occupations. Where a person has some limitation in climbing and balancing and it is the only limitation, it would not ordinarily have a significant impact on the broad world of work. Certain occupations, however, may be ruled out; e.g., the light occupation of construction painter, which requires climbing ladders and scaffolding, and the very heavy occupation of fire-fighter, which sometimes requires the individual to climb poles and ropes. Where the effects of a person's actual limitations of climbing and balancing on the occupational base are difficult to determine, the services of a VS may be necessary.

b. *Stooping, kneeling, crouching, and crawling* are progressively more strenuous forms of bending parts of the body, with crawling as a form of locomotion involving bending. Some stooping (bending the body downward and forward by bending the spine at the waist) is required to do almost any kind of work, particularly when objects below the waist are involved. If a person can stoop occasionally (from very little up to one-third of the time) in order to lift objects, the sedentary and light occupational base is virtually intact. However, because of the lifting requirements for most medium, heavy, and very heavy jobs, a person must be able to stoop frequently (from one-third to two-thirds of the time); inability to do so would substantially affect the more strenuous portion of the occupational base. This is also true for crouching (bending the body downward and forward by bending both the legs and spine). However, crawling on hands and knees and feet is a relatively rare activity even in arduous work, and limitations on the ability to crawl would be of little significance in the broad world of work. This is also true of kneeling (bending the legs at the knees to come to rest on one or both knees).

c. *Reaching, handling, fingering, and feeling* require progressively finer usage of the upper extremities to perform work-related activities. Reaching (extending the hands and arms in any direction) and handling (seizing, holding, grasping, turning or otherwise working primarily with the whole hand or hands) are activities required in almost all jobs. Significant limitations of reaching or handling, therefore, may eliminate a large number of occupations a person could otherwise do. Varying degrees of limitations would have different effects, and the assistance of a VS may be needed to determine the effects of the limitations. "Fingering" involves picking, pinching, or otherwise working primarily with the fingers. It is needed to perform most unskilled sedentary jobs and to perform certain skilled and semiskilled jobs at all levels of exertion. As a general rule, limitations of fine manual dexterity have greater adjudicative significance — in terms of relative number of jobs in which the function is required — as the person's exertional RFC decreases. Thus, loss of fine manual dexterity narrows the sedentary and light ranges of work much more than it does the medium, heavy, and very heavy ranges of work. The varying degrees of loss which can occur may require a decisionmaker to have the assistance of a VS. However, a VS would not ordinarily be required where a

person has a loss of ability to feel the size, shape temperature, or texture of an object by the fingertips, since this is a function required in very few jobs.

3. Hearing Impairments

Communication is an important factor in work. The inability to hear, because it vitally affects communication, is thus of great importance. However, hearing impairments do not necessarily prevent communication, and differences in types of work may be compatible with various degrees of hearing loss. Occupations involving loud noise, such as in printing, have traditionally attracted persons with hearing impairments, whereas individuals with normal hearing have to wear ear protectors to be able to tolerate the working conditions. On the other hand, occupations such as bus driver require good hearing. There are so many possible medical variables of hearing loss that consultation of vocational reference materials or the assistance of a VS is often necessary to decide the effect on the broad world of work.

4. Visual Impairment

As a general rule, even if a person's visual impairment(s) were to eliminate all jobs that involve very good vision (such as working with small objects or reading small print), as long as he or she retains sufficient visual acuity to be able to handle and work with rather large objects (and has the visual fields to avoid ordinary hazards in a workplace), there would be a substantial number of jobs remaining across all exertional levels. However, a finding of disability could be appropriate in the relatively few instances in which the claimant's vocational profile is extremely adverse, e.g., closely approaching retirement age, limited education or less, unskilled or no transferable skills, and essentially a lifetime commitment to a field of work in which good vision is essential.

5. Environmental Restriction

A person may have the physical and mental capacity to perform certain functions in certain places, but to do so may aggravate his or her impairment(s) or subject the individual or others to the risk of bodily injury. Surroundings which an individual may need to avoid because of impairment include those involving extremes of temperature, noise, and vibration; recognized hazards such as unprotected elevations and dangerous moving machinery; and fumes, dust, and poor ventilation. A person with a seizure disorder who is restricted only from being on unprotected elevations and near dangerous moving machinery is an example of someone whose environmental restriction does not have a significant effect on work that exist at all exertional levels.

Where a person has a medical restriction to avoid excessive amounts of noise, dust, etc., the impact on the broad world of work would be minimal because most job environments do not involve great noise, amounts of dust, etc.

Where an individual can tolerate very little noise, dust, etc., the impact on the ability to work would be considerable because very few job environments are entirely free of irritants, pollutants, and other potentially damaging conditions.

Where the environmental restriction falls between very little and excessive, resolution of the issue will generally require consultation of occupational reference materials or the services of a VS.

EFFECTIVE DATE:

Final regulations providing the Medical-Vocational Guidelines were published in the *Federal Register* on November 28, 1978, at FR 55349, effective February 26, 1979. They were rewritten to make them easier to understand and were published on August 20, 1980, at 45 FR 55566. The policies in this PPS also became effective as of February 26, 1979.

CROSS-REFERENCES:

Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures) sections DI 00401.691 and 00401.694; [SSR 83-10](#), PPS-101, Determining Capability to Do Other Work — The Medical-Vocational Rules of Appendix 2 (with a glossary); [SSR 83-11](#), PPS-102, Capability to Do Other Work — The Exertionally Based Medical-Vocational Rules Met; [SSR 83-12](#), PPS-103, Capability to Do Other Work — The Medical-Vocational Rules as a Framework for Evaluating Exertional Limitations Within a Range of Work or Between Ranges of Work or Between Ranges of Work; and [SSR 83-14](#), PPS-105, Capability to Do Other Work — The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments.

IV.F.5.c. TITLES II AND XVI: RESIDUAL FUNCTIONAL CAPACITY FOR MENTAL IMPAIRMENTS: SSR 85-16

SSR 85-16

This supersedes Program Policy Statement (PPS) No. 117 (Social Security Ruling (SSR) 85-8), Titles II and XVI: Residual Functional Capacity (RFC) for Mental Impairments (which superseded PPS No. 97 (SSR 83-16) with the same title).

PURPOSE:

To state the policy and describe the issues to be considered when an individual with a mental impairment requires an assessment of the residual functional capacity (RFC) in order to determine the individual's capacity to engage in basic work-related activities.

CITATIONS (AUTHORITY):

Sections [223\(d\)](#), [216\(i\)](#) and [1614\(a\)](#) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections [404.1545](#), [404.1546](#), and [Appendix 1, Part A, section 12.00](#), and Regulations No. 16, Subpart I, sections [416.945](#), [416.946](#).

INTRODUCTION:

An individual whose impairment(s) meets, or is medically equivalent to, the requirements of an impairment(s) contained in the Listing of Impairments is considered unable to function adequately in work-related activities. On the other hand, an individual whose impairment is found to be not severe is considered not to be significantly restricted in the ability to engage in basic work-related activities. An individual whose impairment(s) falls between these two levels has a significant restriction in the ability to engage in some basic work-related activities. It is, therefore, necessary to determine the RFC for these individuals. This policy statement provides guides for the determination of RFC for individuals whose mental impairment(s) does not meet or equal the listing, but is more than not severe.

POLICY STATEMENT:*Importance of RFC Assessments in Mental Disorders*

Medically determinable mental disorders present a variable continuum of symptoms and effects, from minor emotional problems to bizarre and dangerous behavior. However, in determining the impact of a mental disorder on an individual's capacities, essentially the same impairment-related medical and nonmedical information is considered to determine whether the mental disorder meets listing severity as is considered to determine whether the mental impairment is of lesser severity, yet diminishes the individual's RFC. For impairments of listing severity, inability to perform substantial gainful activity (SGA) is presumed from prescribed findings. However, with mental impairments of lesser severity, such inability must be demonstrated through a detailed assessment of the individual's capacity to perform and sustain mental activities which are critical to work performance. Conclusions of ability to engage in SGA are not to be inferred merely from the fact that the mental disorder is not of listing severity.

Regulations No. 4, section [404.1545\(c\)/416.945\(c\)](#), presents the broad issues to be considered in the evaluation of RFC in mental disorders. It states that this evaluation includes consideration of the ability to understand, to carry out and remember instructions and to respond appropriately to supervision, coworkers, and customary work pressures in a work setting. Consideration of these factors, which are contained in section 12.00 of the Listing of Impairments in Appendix 1, is required for the proper evaluation of the severity of mental impairments.

The determination of mental RFC involves the consideration of evidence, such as:

- History, findings, and observations from medical sources (including psychological test results), regarding the presence, frequency, and intensity of hallucinations, delusions or

paranoid tendencies; depression or elation; confusion or disorientation; conversion symptoms or phobias; psychophysiological symptoms, withdrawn or bizarre behavior; anxiety or tension.

- Reports of the individual's activities of daily living and work activity, as well as testimony of third parties about the individual's performance and behavior.
- Reports from workshops, group homes, or similar assistive entities.

In analyzing the evidence, it is necessary to draw meaningful inferences and allow reasonable conclusions about the individual's strengths and weaknesses. Consideration should be given to factors such as:

- Quality of daily activities, both in occupational and social spheres (see Listing 12.00, Introduction), as well as of the individual's actions with respect to a medical examination.
- Ability to sustain activities, interests, and relate to others *over a period of time*. The frequency, appropriateness, and independence of the activities must also be considered (see PPS No. 96, SSR 83-15, Titles II and XVI: Evaluation of Chronic Mental Impairments).
- Level of intellectual functioning.
- Ability to function in a work-like situation.

When a case involves an individual (except disabled widow(ers) and title XVI children under 18) who has a severe impairment(s), which does not meet or equal the criteria in the Listing of Impairments, the individual's RFC must be considered in conjunction with the individual's age, education, and work experience. While some individuals will have a significant restriction of the ability to perform some work-related activities, not all such activities will be precluded by the mental impairment. However, all limits on work-related activities resulting from the mental impairment must be described in the mental RFC assessment.

It is the responsibility of the program physician or psychologist, the disability hearing officer (DHO), the administrative law judge (ALJ), or the Appeals Council (AC) member to identify the pertinent evidence from medical and nonmedical reports and to make findings as to the individual's ability to perform work-related activities (RFC). The determination of impairment severity and the resulting RFC constitute the medical evaluation of the mental disorder. The determination of "disability," however, depends upon the extent to which the individual has the vocational qualifications to perform work, in light of the restrictions described in the RFC assessment.

Evaluation of Medical and Other Evidence

Medical evidence is critical to determinations of disability. It provides medical history, test results, examination findings, and observations, as well as conclusions of medical

sources trained and knowledgeable in the diagnosis and treatment of diseases and disorders.

Reports from psychiatrists and other physicians, psychologists, and other professionals working in the field of mental health should contain the individual's medical history, mental status evaluation, psychological testing, diagnosis, treatment prescribed and response, prognosis, a description of the individual's daily activities, and a medical assessment describing ability to do work-related activities. These reports may also contain other observations and opinions or conclusions on such matters as the individual's ability to cope with stress, the ability to relate to other people, and the ability to function in a group or work situation.

Medical documentation can often give clues as to functional limitation. For example, evidence that an individual is markedly withdrawn or seclusive suggests a greatly reduced capacity for close contact and interaction with other people. The conclusion of reduced RFC in this area can then be applied to all steps of vocational assessment. For example, when the vocational assessment establishes that the claimant's past work has been limited to work requiring close contact and interaction with other people, the preceding assessment would indicate that the claimant would be unable to fulfill the requirements of his or her past work. Therefore, the determination of disability in this instance would depend on the individual's vocational capacity for other work.

Similarly, individuals with paranoid tendencies may be expected to experience moderate to moderately severe difficulties in relating to coworkers or supervisors, or in tolerating normal work pressures. The ability to respond appropriately to supervision and to coworkers under customary work pressure is a function of a number of different factors, some of which may be unique to a specific work situation.

The evaluation of intellectual functioning by a program physician, psychologist, ALJ, or AC member provides information necessary to determine the individual's ability to understand, to remember instructions, and to carry out instructions. Thus, an individual, in whom the only finding in intellectual testing is an IQ between 60 and 69, is ordinarily expected to be able to understand simple oral instructions and to be able to carry out these instructions under somewhat closer supervision than required of an individual with a higher IQ. Similarly, an individual who has an IQ between 70 and 79 should ordinarily be able to carry out these instructions under somewhat less close supervision.

Since treating medical sources often have considerable information about the development and progress of an individual's impairment, as well as information about the individual's response to treatment, evidence from treating sources should be given appropriate consideration. On occasion, the report of a current treating source may disclose other sources of medical evidence not previously reported. If so, these sources should be contacted, since it is essential that the medical documentation reflect all available sources, particularly in instances of questionable severity of impairment or inconclusive RFC. When medical source notes appear to be incomplete, recontact with the source should be made to attempt to obtain more detailed information. Every

reasonable effort should be made to obtain all medical evidence from the treating source necessary to make a determination of impairment severity and RFC before obtaining evidence from any other source on a consultative basis. However, when treating medical sources cannot provide essential information, consultative examination by a treating or nontreating source may resolve the impairment or RFC issue. Similarly, when the reports from these sources appear to be incomplete, the source should be recontacted to clarify the issues.

Other evidence also may play a vital role in the determination of the effects of impairment. To arrive at an overall assessment of the effects of mental impairment, relevant, reliable information, obtained from third party sources such as social workers, previous employers, family members, and staff members of halfway houses, mental health centers, and community centers, may be valuable in assessing an individual's level of activities of daily living. Information concerning an individual's performance in any work setting (including sheltered work and volunteer or competitive work), as well as the circumstances surrounding the termination of the work effort, may be pertinent in assessing the individual's ability to function in a competitive work environment.

Reports of workshop evaluation may also be of value in assessing the individual's ability to understand, to carry out and remember instructions, and to respond appropriately to supervisors, coworkers, and customary work pressures in a work setting. Consequently, wherever the record shows that a workshop evaluation has been performed, the report should be requested from the source. If no workshop evaluation has been done, but, after complete and comprehensive documentation, genuine doubt remains as to the individual's functional capacity, consideration should be given to obtaining one. Information derived from workshop evaluations must be used in conjunction with the clinical evidence of impairment, but all conflicts between workshop evaluation and evidence and the conclusions based on objective medical findings must be resolved.

Descriptions and observations of the individual's restrictions by medical and other sources (including Social Security Administration representatives, such as district office representatives and ALJ's), in addition to those made during formal medical examinations, must also be considered in the determination of RFC. However, care must be taken not to give duplicate weight to certain findings. For example, a competent psychometric assessment of intellectual functioning provides a sample, referenced to established norms, of the individual capabilities in various areas, including those germane to a workshop situation. Such a psychometric assessment, therefore, usually provides the same impairment-related information about functional capacity that might also be disclosed in the course of a workshop evaluation. Since the effects of the same underlying impairment(s) may be revealed in both assessment approaches, it would be incorrect to consider this duplicate representation of the same impairment to reflect separate and independent impairments. Such an approach would give the same impairment(s) double weight.

Observations and findings from a workshop evaluation may supplement the psychometric assessment or may raise some question concerning the accuracy of the

psychometric assessment. Whenever a significant discrepancy in conclusions between the two arises, an explanation must be given by the program physician, psychologist, ALJ, or AC member for rejecting or modifying the conclusions of the psychometric assessment or the workshop evaluation.

EFFECTIVE DATE: On publication.

CROSS-REFERENCES: Program Operations Manual System, section DI 00401.592.

IV.F.5.d. Mental Disorders Listings – Paragraph B Criteria Quick Reference Guide

**Mental Disorders Listings – Paragraph B Criteria
Quick Reference Guide**

Paragraph B1 – Understand, Remember, or Apply Information	Paragraph B2 – Interact with Others	Paragraph B3 – Concentrate, Persist, or Maintain Pace	Paragraph B4 – Adapt or Manage Oneself
Examples of this area of mental functioning include:			
<ul style="list-style-type: none"> • Understanding and learning terms, instructions, and procedures • Following one- or two-step oral instructions to carry out a task • Describing work activity to someone else • Asking and answering questions and providing explanations • Recognizing a mistake and correcting it • Identifying and solving problems • Sequencing multi-step activities • Using reason and judgment to make work-related decisions 	<ul style="list-style-type: none"> • Cooperating with others • Asking for help when needed • Handling conflicts with others • Stating one's own point of view • Initiating or sustaining conversation • Understanding and responding to social cues, including physical, verbal, and emotional cues • Responding to requests, suggestions, criticism, correction, and challenges • Keeping social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness 	<ul style="list-style-type: none"> • Initiating and performing a task that the person understands and knows how to do • Working at an appropriate and consistent pace • Completing tasks in a timely manner • Ignoring or avoiding distractions while working • Changing activities or work settings without being disruptive • Working close to or with others without interrupting or distracting them • Sustaining an ordinary routine and regular attendance at work • Working a full day without needing more than the allotted number or length of rest periods 	<ul style="list-style-type: none"> • Responding to demands • Adapting to changes • Managing psychologically based symptoms • Distinguishing between acceptable and unacceptable work performance • Setting realistic goals • Making plans independently of others • Maintaining personal hygiene and attire appropriate to a work setting • Being aware of normal hazards and taking appropriate precautions

Office of Disability Policy
Effective January 17, 2017

IV.F.5.e. 12.05 Intellectual disorder (see 12.00B4), satisfied by A or B:

A. Satisfied by 1, 2, and 3 (see 12.00H):

1. Significantly subaverage general intellectual functioning evident in your cognitive inability to function at a level required to participate in standardized testing of intellectual functioning; and
2. Significant deficits in adaptive functioning currently manifested by your dependence upon others for personal needs (for example, toileting, eating, dressing, or bathing); and

3. The evidence about your current intellectual and adaptive functioning and about the history of your disorder demonstrates or supports the conclusion that the disorder began prior to your attainment of age 22.

OR

- B. Satisfied by 1, 2, and 3 (see 12.00H):
 1. Significantly subaverage general intellectual functioning evidenced by a or b:
 - a. A full scale (or comparable) IQ score of 70 or below on an individually administered standardized test of general intelligence; or
 - b. A full scale (or comparable) IQ score of 71-75 accompanied by a verbal or performance IQ score (or comparable part score) of 70 or below on an individually administered standardized test of general intelligence; and
 2. Significant deficits in adaptive functioning currently manifested by extreme limitation of one, or marked limitation of two, of the following areas of mental functioning:
 - a. Understand, remember, or apply information (see 12.00E1); or
 - b. Interact with others (see 12.00E2); or
 - c. Concentrate, persist, or maintain pace (see 12.00E3); or
 - d. Adapt or manage oneself (see 12.00E4); and
 3. The evidence about your current intellectual and adaptive functioning and about the history of your disorder demonstrates or supports the conclusion that the disorder began prior to your attainment of age 22.