

A “Whole” New Approach to Functional Equivalence—The Childhood Disability Social Security Rulings

On February 17 and 18, 2009, SSA issued eight new Social Security Rulings addressing childhood SSI disability determinations. The eight SSRs, all effective March 20, 2009, provide guidance on application of the fourth step of the childhood SSI disability sequential evaluation—the functional equivalence test. The first two SSRs—SSR 09-1p (Determining Childhood Disability Under the Functional Equivalence Rule—The “Whole Child” Approach) and SSR 09-2p (Determining Childhood Disability—Documenting a Child’s Impairment-Related Limitations) address overall aspects of the functional equivalence process. SSA also issued six SSRs—one for each of the six domains of functioning that are part of the functional equivalence process:

- 09-3p Acquiring and Using Information
- 09-4p Attending and Completing Tasks
- 09-5p Interacting and Relating with Others
- 09-6p Moving About and Manipulating Objects
- 09-7p Caring for Yourself
- 09-8p Health and Physical Well-Being

The SSRs provide guidance on applying functional equivalence that previously had only been set forth in various training materials provided to SSA staff.

A. Introduction

At the fourth step of the SSI childhood disability sequential evaluation,¹ a child can be found disabled if he or she functionally equals the listings. To functionally equal the listings, an impairment(s) must be of listing-level severity; that is, it must result in “marked” limitations in two domains or an “extreme” limitation” in one domain.² Domains are broad areas of functioning intended to capture all of what a child can or cannot do. SSA uses the following six domains:

- Acquiring and using information;
- Attending and completing tasks;
- Interacting and relating with others;
- Moving about and manipulating objects;
- Caring for yourself; and
- Health and physical well-being.

The functional equivalence test is completely separate from the listing analyses done to

¹ 20 C.F.R. § 416.924(b)-(d).

² 20 C.F.R. § 416.926a(a).

determine if a child meets or medically equals the listings.

B. The “Whole Child” Approach to Functional Equivalence.

SSR 09-1p provides an overview of the “whole child” approach:

The functional equivalence rules require us to begin by considering how the child functions every day and in all settings compared to other children the same age who do not have impairments. After we determine how the child functions in all settings, we use the domains to create a picture of how, and the extent to which, the child is limited by identifying the activities that are used to do each activity, and assigning each activity to any and all domains involved in doing it. We then determine whether the child’s medically determinable impairment(s) accounts for the limitations we have identified. Finally, we rate the overall severity of limitation in each domain to determine whether the child is “disabled” as defined in the Act.

SSR 09-1p then poses four questions to apply the “whole child” approach:

1. How does the child function?

This analysis includes the following:

- what activities the child is able to do;
- what activities the child is unable to do;
- which of the child’s activities are limited or restricted;
- where the child has difficulty with activities—at home, in childcare, at school, and the community; whether the child has difficulty initiating, sustaining, or completing activities;
- the kind of help, and how much help the child needs to do activities, and how often the child needs it; and
- whether the child needs a structured or supportive setting, what kind of structure or support is required, and how often the child needs it.³

SSR 09-2p makes clear that evidence that shows what a child can and cannot do, as discussed above, is derived from both medical and non-medical sources:

Once we have evidence from an acceptable medical source that establishes the existence of at least one medically determinable impairment,⁴ we consider all relevant evidence in the case record to determine whether a child is disabled. This evidence may come from

³ SSR 09-1p.

⁴ This requirement is satisfied at step two of the childhood sequential evaluation; a child must show an impairment or combination of impairments that is “severe.” See SSR 09-1p, fn. 11.

acceptable medical sources and from a wide variety of “other” sources.⁵

2. Which domains are involved in performing the activities in which the child has trouble in functioning?

This step requires knowledge of what limitations belong with what domain. The specific domains are discussed below. Each domain is defined in 20 C.F.R. § 416.926a; the regulation provides a general description of the domain, age group descriptors for five age groups from birth to attainment of age 18; and some examples of limited functioning in the domain. In addition, SSA has now issued an SSR that addressed each domain specifically. The SSRs supplement the regulations by including examples of impairments that cause functional limitations in that domain; discussion of the multiple effects of impairments and functional limitations; examples of typical functioning for each of the five age groups; and examples of limited functioning. These training materials contain tables, for each of the five age groups, that set forth the examples of typical functioning in each of the six domains.

In SSR 09-1p, SSA provides an example of this process, detailing the functional limitations of an eight-year-old child with generalized anxiety disorder that did not meet Listing 112.06. In a chart that contains a column for each of the six domains, SSA sets forth specific limitations that the child has. For example, in the domain of Attending and Completing Tasks, the example noted that the child’s “[a]ttention at school is reduced; has trouble focusing in class; does little work in class or at home.”

Acquiring & Using Information	Attending & completing tasks	Interacting & Relating with Others	Moving about & manipulating objects	Caring for yourself	Health & Physical Well-Being
Does little work in class or at home and has fallen behind; may not be promoted to next grade.	Attention at school is reduced, has trouble focusing in class; does little work in class or at home.	Despite orders from mother, refuses to go to bed; will not stay in bed; gets up to watch TV until he falls asleep. Is combative at home. Sometimes refuses to leave classroom for activities and requires aide to stay with him.	No limitations	Difficulty sleeping; afraid of dark and outside noises; tries to stay awake and keep eyes open at night; is irritable due to lack of sleep; cries when he has to go to school; anxiety scale shows GAD. Child receives play therapy.	Pediatrician has tried short-term Valium; child has complained of stomach cramps and headache; tried short-term Ativan; side effects were dizziness and daytime sleepiness.

Both 20 C.F.R. § 416.926a(c) and SSR 09-1p make clear that a child’s functional limitations could be placed in more than one domain category. SSR 09-1p provides as follows:

The “whole child” approach recognizes that many activities require the use of more than one of the abilities described in the first five domains, and that they may also be affected

⁵ “Other” sources are defined at 20 C.F.R. § 416.913(d) and include nurse-practitioners, audiologists, therapists, educational personnel, public and private social welfare agency personnel, and others including parents, other caregivers, siblings, other relatives, and neighbors.

by a problem that we consider in the sixth domain. A single impairment, as well as a combination of impairments, may result in limitations that require evaluation in more than one domain.⁶ Conversely, a combination of impairments, as well as a single impairment, may result in limitations that we rate in only one domain.

SSR 09-1p. This concept is set forth at 20 C.F.R. § 416.926a(c) (“Interactive and Cumulative Effects of an Impairment”).⁷

3. *Could the child’s medically determinable impairment(s) account for limitations in the child’s activities?*

In describing this step, SSR 09-1p provides:

If [a child’s medically determinable impairments] could [account for limitations], and there is no evidence to the contrary, [SSA] conclude[s] that the impairment(s) causes the activity limitations we have identified in each domain.

However, the functional limitations caused by medical impairments in some domains may not be obviously relevant. The SSRs dealing with each domain provides examples of impairments that may cause functional limitations in domains other than the most expected domain.

SSR 09-1p provides an example of an adolescent with a diagnosis of borderline intellectual functioning. The non-medical evidence shows that the child has been inattentive in school and failed subjects for failure to complete assigned work. She also frequently refuses to go to school and has sleep and behavior problems at home. Despite several attempts, her parents have been unsuccessful in getting her to talk and accept help. SSR 09-1p provides that the child’s difficulty with activities at school and home could involve three to four domains:

1. Her many years of placement in special education classes for all academic work indicate a limitation ... in the domain of “Acquiring and using information.”
2. Her inattention in class and current failure in three academic subjects as a consequence indicates that there is also a limitation in the domain of “Attending and

⁶ “Rating the limitation caused by a child’s impairment(s) in each and every domain that is affected is *not* “double-weighting” of either the impairment(s) or its effects. Rather, it recognizes the particular effects of the child’s impairment(s) in all domains involved in the child’s limited activities.” SSR 09-1p, fn. 11.

⁷ 20 C.F.R. § 416.926a(c) provides as follows:

Any given activity may involve the integrated use of many abilities and skills; therefore, any single limitation may be the result of the interactive and cumulative effects of one or more impairments. And any given impairment may have effects in more than one domain; therefore, we will evaluate the limitations from your impairment(s) in any affected domain(s).

- completing tasks.”
3. Her mother’s description of some of the child’s difficulties at home (for example, crying, oversleeping, physical complaints, and irritability) and the child’s avoidance of dealing with them indicate a limitation in the domain of “Caring for yourself.”
 4. In addition, if her refusal to talk with her mother and her anger and uncooperativeness exceed what would be expected of adolescents of the same age who do not have any impairments, this would also indicate a limitation in the domain of “Interacting and relating with others.”

Several of the SSRs addressing specific domains address this issue as well. SSR 09-3p (Acquiring and using information) provides as follows:

Children who have physical impairments that affect motor functioning ... may also have limitations in the domain of “Acquiring and using information.” Symptoms associated with a physical impairment(s), such as generalized or localized pain, may interfere with a child’s ability to concentrate (an effect we evaluate in the domain of “Attending and completing tasks”), and this will often also have effects on the child’s ability in the domain of “Acquiring and using information.” Lastly, some medications for physical impairments may affect mental functioning, interfering with a child’s ability to pay attention, remember, or follow directions. We consider these effects in the domains of “Acquiring and using information,” “Attending and completing tasks,” or both.

SSR 09-4p (Attending and completing tasks) provides as follows:

For example, school-age children with AD/HD may have limitations in multiple domains. The effects of inattention and hyperactivity can impede the learning process and affect competence in many areas of life. These effects can result in limitations in the domain of “Acquiring and using information”; for example, by undermining academic performance. They may also have effects in the domain of “Interacting and relating with others”; for example, children with AD/HD may interrupt others in conversation or have difficulty taking turns during play activities. They may also cause limitations in the domain of “Caring for yourself”; for example, when a child risks personal safety by not stopping and thinking before doing something.

SSR 09-5p (Interacting and relating with others) provides as follows:

Both physical and mental impairments can affect a child’s ability to relate with others. For example, a child with a physical abnormality, such as a disfiguring burn, a missing limb, or an abnormal gait, or who uses adaptive equipment because of the impairment(s), may have difficulty making friends. A child with an anxiety disorder may have difficulty spending enough time with others to maintain friendships. An autism spectrum disorder may limit a child’s emotional and social responses to others.

SSR 09-7p provides as follows:

Children with limitations in the domain of “Caring for yourself” may also have limitations in other domains. For example, children with impairments that affect self-regulation may have difficulties in school, resulting in a limitation in the domain of “Acquiring and using information” in addition to the domain of “Caring for yourself.” Limitations in caring for self are also frequently found in connection with impairments whose most obvious effects are in other domains. For example, some children with learning disorders, which have effects in the domain of “Acquiring and using information,” also have difficulties with self-regulation.

Thus, the questions asked in step one above (what activities the child is able and not able to do, etc.) are crucially important. Focusing only on medically determinable impairments could lead advocates to ignore relevant evidence of disability in domains not obviously relevant to a child’s medically determinable impairment(s).

4. *To what degree does the impairment(s) limit the child’s ability to function age-appropriately in each domain?*

Once a child’s limited activities are identified, linked to an underlying medical impairment, and assigned to the appropriate domain, the degree of severity is rated to assess whether the child has marked limitations in two domains or an extreme limitation in one domain.

SSR 09-01p provides some guidance on assessing the degree of limitation in functioning and determining whether those limitations are “markedly” or “extremely” limited. The first consideration is the extent to which the child has factors that “mask” the severity of the functional limitation. SSR 09-01p provides in relevant part:

[W]e consider the kinds of help or support the child needs in order to function. See 20 CFR 416.924a(b). In general, if a child needs a person, medication, treatment, device, or structured, supportive setting to make his functioning possible or to improve the functioning, the child will not be as independent as same-age peers who do not have impairments. Such a child will have a limitation, even if he is functioning well with the help or support.

The more help or support of any kind that a child receives beyond what would be expected for children the same age without impairments, the less independent the child is in functioning, and the more severe we will find the limitation to be.⁸

In terms of rating severity, SSR 09-1p states that it “use[s] a picture constructed of the child’s functioning in each domain.... The rating of limitation in a domain is then based on answers to these questions:

1. How many of the child’s activities in the domain are limited (for example, one, few, several, many, or all)?

⁸ See also SSR 09-2p.

2. How important are the limited activities to the child's age-appropriate functioning (for example, basic, marginally important, or essential)?
3. How frequently do the activities occur and how frequently are they limited (for example, daily, once a week, or only occasionally)?
4. Where do the limitations occur (for example, only at home or in all settings)?
5. What factors are involved in the limited activities (for example, does the child receive support from a person, medication, treatment, device, or structured/supportive settings)?

Additional discussion of rating severity is set forth in Section D.

C. The Six Domains

The new functional equivalence test assesses a child's functional limitations in six areas. In the final regulations, SSA provides a definition for each domain, adds language that addresses each domain based on a child's age,⁹ and provides some examples of functional limitations in each domain. Each of the six domains is discussed below:

1. Acquiring and Using Information

This domain is defined as how well a child acquires or learns information, and how well the child uses the information the child has learned. The final regulations provide further as follows:

(i) Learning and thinking begin at birth. You learn as you explore the world through sight, sound, taste, touch, and smell. As you play, you acquire concepts and learn that people, things, and activities have names. This lets you understand symbols, which prepares you to use language for learning. Using the concepts and symbols you have acquired through play and learning experiences, you should be able to learn to read, write, do arithmetic, and understand and use new information.

(ii) Thinking is the application or use of information you have learned. It involves being able to perceive relationships, reason, and make logical choices. People think in different ways. When you think in pictures, you may solve a problem by watching and imitating

⁹ Each of the five domains--excluding health and physical well-being--contain age-appropriate criteria for the following age groups:

newborns and young infants--birth to attainment of age 1;
older infants and toddlers--age 1 to attainment of age 3;
preschool children--age 3 to attainment of age 6;
school-age children--age 6 to attainment of age 12; and
adolescents--age 12 to attainment of age 18).

20 C.F.R. §§ 416.926a(g)–(k).

what another person does. When you think in words, you may solve a problem by using language to talk your way through it. You must also be able to use language to think about the world and to understand others and express yourself; e.g., to follow directions, ask for information, or explain something.¹⁰

SSR 09-3p provides examples of typical behaviors for different age groups (birth to 1, 1 to 3, 3-6, 6-12, and 12-18). Those activities are set forth in tables at the end of this document.

2. Attending and Completing Tasks

This domain is defined as how well a child is able to focus and maintain his or her attention, and how well the child begins, carries through, and finishes his or her activities, including the pace at which the child performs activities and the ease with which the child changes them.¹¹ The final regulations provide further as follows:

(i) Attention involves regulating your levels of alertness and initiating and maintaining concentration. It involves the ability to filter out distractions and to remain focused on an activity or task at a consistent level of performance. This means focusing long enough to initiate and complete an activity or task, and changing focus once it is completed. It also means that if you lose or change your focus in the middle of a task, you are able to return to the task without other people having to remind you frequently to finish it.

(ii) Adequate attention is needed to maintain physical and mental effort and concentration on an activity or task. Adequate attention permits you to think and reflect before starting or deciding to stop an activity. In other words, you are able to look ahead and predict the possible outcomes of your actions before you act. Focusing your attention allows you to attempt tasks at an appropriate pace. It also helps you determine the time needed to finish a task within an appropriate timeframe.¹²

SSR 09-4p provides examples of typical behaviors for different age groups (birth to 1, 1 to 3, 3-6, 6-12, and 12-18). Those activities are set forth in tables at the end of this document.

3. Interacting and Relating With Others.

This domain is defined as how well a child initiates and sustains emotional connections with others, develops and uses the language of the child's community, cooperates with others, complies with rules, responds to criticism, and respects and takes care of the possessions of others.¹³ The final regulations provide further as follows:

¹⁰ 20 C.F.R. § 416.926a(g).

¹¹ 20 C.F.R. § 416.926a(h).

¹² 20 C.F.R. § 416.926a(h).

¹³ 20 C.F.R. § 416.926a(i).

(i) Interacting means initiating and responding to exchanges with other people, for practical or social purposes. You interact with others by using facial expressions, gestures, actions, or words. You may interact with another person only once, as when asking a stranger for directions, or many times, as when describing your day at school to your parents. You may interact with people one-at-a-time, as when you are listening to another student in the hallway at school, or in groups, as when you are playing with others.

(ii) Relating to other people means forming intimate relationships with family members and with friends who are your age, and sustaining them over time. You may relate to individuals, such as your siblings, parents or best friend, or to groups, such as other children in childcare, your friends in school, teammates in sports activities, or people in your neighborhood.

(iii) Interacting and relating require you to respond appropriately to a variety of emotional and behavioral cues. You must be able to speak intelligibly and fluently so that others can understand you; participate in verbal turntaking and nonverbal exchanges; consider others' feelings and points of view; follow social rules for interaction and conversation; and respond to others appropriately and meaningfully.

(iv) Your activities at home or school or in your community may involve playing, learning, and working cooperatively with other children, one-at-a-time or in groups; joining voluntarily in activities with the other children in your school or community; and responding to persons in authority (e.g., your parent, teacher, bus driver, coach, or employer).¹⁴

SSR 09-5p contains a discussion of the difference between the domains of “Interacting and relating with others” and “Caring for yourself.” It provides as follows:

The domain of “Interacting and relating with others” involves a child’s feelings and behavior in relation to *other people* (as when the child is playing with other children, helping a grandparent, or listening carefully to a teacher). The domain of “Caring for yourself” involves a child’s feelings and behavior in relation to *self* (as when controlling stress in age-appropriate manner).

SSR 09-5p provides examples of typical behaviors for different age groups (birth to 1, 1 to 3, 3-6, 6-12, and 12-18). Those activities are set forth in tables at the end of this document.

4. Moving About and Manipulating Objects

This domain is defined as how a child moves his or her body from one place to another

¹⁴ 20 C.F.R. § 416.926a(i).

and how the child moves and manipulates things. Put another way, this domain assesses gross and fine motor skills.¹⁵ The final regulations provide further as follows:

(i) Moving your body involves several different kinds of actions: Rolling your body; rising or pulling yourself from a sitting to a standing position; pushing yourself up; raising your head, arms, and legs, and twisting your hands and feet; balancing your weight on your legs and feet; shifting your weight while sitting or standing; transferring yourself from one surface to another; lowering yourself to or toward the floor as when bending, kneeling, stooping, or crouching; moving yourself forward and backward in space as when crawling, walking, or running, and negotiating different terrains (e.g., curbs, steps, and hills).

(ii) Moving and manipulating things involves several different kinds of actions: Engaging your upper and lower body to push, pull, lift, or carry objects from one place to another; controlling your shoulders, arms, and hands to hold or transfer objects; coordinating your eyes and hands to manipulate small objects or parts of objects.

(iii) These actions require varying degrees of strength, coordination, dexterity, pace, and physical ability to persist at the task. They also require a sense of where your body is and how it moves in space; the integration of sensory input with motor output; and the capacity to plan, remember, and execute controlled motor movements.¹⁶

SSR 09-6p provides guidance on the difference between the domain of “Moving about and manipulating objects” and the domain of “Health and physical well-being:”

In the domain of “Moving about and manipulating objects,” we consider how well children are able to move their own bodies and handle things. We evaluate limitations of fine and gross motor movements caused by musculoskeletal and neurological impairments, by other impairments (including mental disorders) that may result in motor limitations, and by medications or other treatment or other treatments that cause such limitations.

In the domain of “Health and physical well-being,” we consider the cumulative physical effects of physical and mental impairments and their associated treatments or therapies not addressed in the domain of “Moving about and manipulating objects.” We evaluate the problems of children who are physically ill or who manifest physical effects of mental impairments (except for effects on motor functioning). Physical effects, such as pain, weakness, dizziness, nausea, reduced stamina, or recurrent infections, may result from the impairment(s) itself, from medications or other treatment, or from chronic illness. These effects can determine whether a child feels well enough and has sufficient energy to

¹⁵ 20 C.F.R. § 416.926a(j).

¹⁶ 20 C.F.R. § 416.926a(j).

engage in age-appropriate activities, either alone or with other children.

SSR 09-6p.

SSR 09-6p provides examples of typical behaviors for different age groups (birth to 1, 1 to 3, 3-6, 6-12, and 12-18). Those activities are set forth in tables at the end of this document.

5. Caring For Yourself

This domain is defined as how well a child maintains a healthy emotional and physical state, including how well the child gets his or her physical and emotional wants and needs met in appropriate ways; how the child copes with stress and changes in his or her environment; and whether the child takes care of his or her own health, possessions, and living area.¹⁷ The final regulations provide further as follows:

(i) Caring for yourself effectively, which includes regulating yourself, depends upon your ability to respond to changes in your emotions and the daily demands of your environment to help yourself and cooperate with others in taking care of your personal needs, health and safety. It is characterized by a sense of independence and competence. The effort to become independent and competent should be observable throughout your childhood.

(ii) Caring for yourself effectively means becoming increasingly independent in making and following your own decisions. This entails relying on your own abilities and skills, and displaying consistent judgment about the consequences of caring for yourself. As you mature, using and testing your own judgment helps you develop confidence in your independence and competence. Caring for yourself includes using your independence and competence to meet your physical needs, such as feeding, dressing, toileting, and bathing, appropriately for your age.

(iii) Caring for yourself effectively requires you to have a basic understanding of your body, including its normal functioning, and of your physical and emotional needs. To meet these needs successfully, you must employ effective coping strategies, appropriate to your age, to identify and regulate your feelings, thoughts, urges, and intentions. Such strategies are based on taking responsibility for getting your needs met in an appropriate and satisfactory manner.

(iv) Caring for yourself means recognizing when you are ill, following recommended treatment, taking medication as prescribed, following safety rules, responding to your circumstances in safe and appropriate ways, making decisions that do not endanger yourself, and knowing when to ask for help from others.¹⁸

¹⁷ 20 C.F.R. § 416.926a(k).

¹⁸ 20 C.F.R. § 416.926a(k).

SSR 09-7p provides a good discussion of the difference between it and the domain of “Interacting and relating with others.” See discussion in Interacting and Relating with Others section above.

SSR 09-7p provides examples of typical behaviors for different age groups (birth to 1, 1 to 3, 3-6, 6-12, and 12-18). Those activities are set forth in tables at the end of this document.

6. Health and Physical Well-Being

This domain is defined as the cumulative physical effects of physical or mental impairments and their associated treatments or therapies on the child’s functioning that SSA did not consider in the domain of Moving about and manipulating objects. When the child’s physical impairment(s), his or her mental impairment(s), or his or her combination of physical and mental impairments has physical effects that cause “extreme” limitation in the child’s functioning, the child will generally have an impairment(s) that “meets” or “medically equals” a listing.¹⁹ The federal regulations further provide as follows:

- (1) A physical or mental disorder may have physical effects that vary in kind and intensity, and may make it difficult for you to perform your activities independently or effectively. You may experience problems such as generalized weakness, dizziness, shortness of breath, reduced stamina, fatigue, psychomotor retardation, allergic reactions, recurrent infection, poor growth, bladder or bowel incontinence, or local or generalized pain.
- (2) In addition, the medications you take (e.g., for asthma or depression) or the treatments you receive (e.g., chemotherapy or multiple surgeries) may have physical effects that also limit your performance of activities.
- (3) Your illness may be chronic with stable symptoms, or episodic with periods of worsening and improvement. We will consider how you function during periods of worsening and how often and for how long these periods occur. You may be medically fragile and need intensive medical care to maintain your level of health and physical well-being. In any case, as a result of the illness itself, the medications or treatment you receive, or both, you may experience physical effects that interfere with your functioning in any or all of your activities.²⁰

SSR 09-8p provides the following examples of limitations:

- Has generalized symptoms caused by an impairment(s) (for example, tiredness

¹⁹ 20 C.F.R. § 416.926a(l).

²⁰ Id.

- due to depression).
- Has somatic complaints related to an impairment(s) (for example, epilepsy).
 - Has chronic medication side effects (for example, dizziness).
 - Needs frequent treatment or therapy (for example, multiple surgeries or chemotherapy).
 - Experiences periodic exacerbations (for example, pain crises in sickle cell anemia).
 - Needs intensive medical care as a result of being medically fragile.

SSR 09-8p provides a discussion between it and the domain of “Moving about and manipulating objects.”

D. Determining When Functional Limitations Are “Marked” or “Extreme”

In assessing childhood disability, decision makers must determine whether limitations in a domain or domains rise to the level of “marked” or “extreme.” As discussed earlier, a child is disabled under the functional equivalence test if he or she has marked limitations in at least two domains or an extreme limitation in at least one domain.²¹

1. Definition of “Marked” Limitations

SSA will find a limitation to be “marked” when it **interferes seriously** with the child’s ability to independently initiate, sustain, or complete activities. A “marked” limitation also means a limitation that is “more than moderate” but “less than extreme” and is the equivalent of the functioning expected when standardized test scores are at least two, but less than three, standard deviations below the mean.

For children up to age three, SSA will generally find a “marked” limitation if the child is functioning at a level that is more than one-half but not more than two-thirds of the child’s chronological age when there are no standard scores from standardized tests in the child’s case record.²²

For all children (birth to the attainment of age 18), SSA will find that a child has a “marked” limitation when the child has a valid score that is two standard deviations or more below the mean, but less than three standard deviations, on a comprehensive standardized test designed to measure ability or functioning in that domain, and your day-to-day functioning in domain-related activities is consistent with that score.²³

Under the Health and physical well-being domain, a limitation is considered “marked” in

²¹ 20 C.F.R. § 416.926a(d).

²² 20 C.F.R. § 416.926a(e)(2)(ii).

²³ 20 C.F.R. § 416.926a(e)(3)(iii)

the following circumstance:

if [a child is] frequently ill because of [his or her] impairment(s) or have frequent exacerbations of your impairment(s) that result in significant, documented symptoms or signs. For purposes of this domain, “frequent means that you have episodes of illness or exacerbations that occur on an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more. We may also find that you have a “marked” limitation if you have episodes that occur more often than 3 times in a year or once every 4 months but do not last for 2 weeks, or occur less often than an average of 3 times a year or once every 4 months but last longer than 2 weeks, if the overall effect (based on the length of the episode(s) or its frequency) is equivalent in severity.”²⁴

2. Definition of “Extreme” Limitation

SSA will find a functional limitation to be extreme if it interferes **very seriously** with a child’s ability to independently initiate, sustain, or complete activities. A child’s day-to-day functioning may be very seriously limited when an impairment(s) limits only one activity or when the interactive and cumulative effects of a child’s impairment(s) limit several activities.²⁵ “Extreme” limitation is the rating we give to the worst limitations. However, “extreme limitation” does not necessarily mean a total lack or loss of ability to function. It is the equivalent of the functioning we would expect to find on standardized testing with scores that are at least three standard deviations below the mean.

For children up to age three, SSA will generally find an “extreme” limitation if the child is functioning at a level that is one-half of chronological age or less when there are no standard scores from standardized tests in the case record.²⁶

For children from birth to attainment of age 18, SSA will generally find an “extreme” limitation when the child has a valid score that is three standard deviations or more below the mean on a comprehensive standardized test designed to measure ability or functioning in that domain, and day-to-day functioning in domain-related activities is consistent with that score.²⁷

For the sixth domain of functioning, “Health and physical well-being,” SSA considers a child to have an “extreme” limitation if the child is ill because of impairment(s) or has

²⁴ 20 C.F.R. § 416.926a(e)(2)(iv). The regulation does not define “exacerbation.” However, it stands to reason that exacerbation means something less than an episode so severe that it requires hospitalization as several Listings may be met with showing of three hospitalizations in a 12 month period.

²⁵ 20 C.F.R. § 416.926a(e)(3)(i). The definition also contains the comparative finding that an “extreme” limitation also means a limitation that is “more than marked.” Id.

²⁶ 20 C.F.R. § 416.926a(e)(3)(ii)

²⁷ 20 C.F.R. § 416.926a(e)(3)(iii)

exacerbations of impairment(s) that result in significant, documented symptoms or signs substantially in excess of the requirements for showing a “marked” limitation. SSA further states that if limitations are rated as “extreme” under this definition, the child’s impairment(s) should meet or medically equal the requirements of a listing in most cases.²⁸

3. Treatment of Test Scores

SSA has added a discussion of how it treats test scores in determining whether a child’s limitations are “marked” or “extreme.” This language reflects SSA’s sometimes contradictory approach to test scores. On one hand, SSA decision makers rely heavily on standardized test scores as impartial measures of how the child is functioning compared to other children his or her age. On the other hand, SSA decision makers often seem to have an elemental distrust of testing results that show children have “marked” or “extreme” limitation when those children do not fit their perceptions about how children with such conditions should function.²⁹

SSA’s response has been to set out a series of general rules concerning test scores.³⁰ First, SSA states that its decision makers will not rely on any test score alone because no single piece of information taken in isolation can establish whether [a child has] a “marked” or an “extreme” limitation in a domain.³¹

Second, the regulations state that decision makers could find that a child has a “marked” or “extreme” limitation even if test scores were slightly higher than the level required to show a marked or extreme limitation if other evidence shows that the child’s functioning in day-to-day activities is seriously or very seriously limited due to the impairment(s).³² Conversely, SSA

²⁸ 20 C.F.R. § 416.926a(e)(3)(iv).

²⁹ This disconnect bespeaks the critical importance of ensuring that the factors such as extra help and structured settings are evaluated. For example, one-on-one functioning in a consultative examination, by itself, will not provide an accurate picture of how a child does in Attending and completing tasks.

³⁰ What SSA has not done is set forth guidelines for its decision makers that list tests that it believes are good indicators of specific mental disorders, or to provide discussion of commonly used tests and how to interpret the results of those tests. SSA last issued such a document in 1993. See Memorandum from Acting Associate Commissioner for Disability to All Regional Commissioners, August 26, 1993, reprinted in *Childhood Disability Evaluation Issues*, March 1998 at pp. 91-111. That memorandum does not provide guidance on interpreting those test results. Such information is available, for example, from Sattler, J.M. *Assessment of Children*. J.M. Sattler, Publisher, Inc. San Diego, CA.

³¹ 20 C.F.R. § 416.926a(e)(4).

³² 20 C.F.R. § 416.926a(e)(4)(ii)(A). This commonly arises in cases involving mental retardation, where a child may function in the mentally retarded level, but have test scores slightly above the IQ cutoff for a finding of mental retardation. Such scores could be the result of the standard error of measurement or the cumulative effect of administering such testing. For more information about use of IQ tests in childhood SSI, see SSA Office of Disability, *Childhood Disability Evaluation Issues*, SSA Pub. No. 64-076, March 1998) at pp. 25-37.

decision makers could find that a child does not have a “marked” or “extreme” limitation, even if test scores were above two or three standard deviations below the norm if other evidence shows that functioning in day-to-day activities is not seriously or very seriously limited.³³

Third, if there is a material inconsistency between a child’s test scores and other information in the case record, SSA decision makers must try to resolve it.³⁴ In so doing, the final regulations warn that the interpretation of the test is primarily the function of the psychologist or other professional who administered the test.³⁵ Thus, SSA decision makers are supposed to use the following guidelines when they resolve concerns about test scores:

- SSA may be able to resolve the inconsistency with the information it has, or it may need to obtain additional information; e.g., by recontact with the child’s medical source(s), by purchase of a consultative examination to provide further medical information, by recontact with a medical source who provided a consultative examination, or by questioning individuals familiar with the child’s day-to-day functioning;³⁶ and
- SSA will not generally rely on a test score as a measurement of a child’s functioning within a domain when the information we have about your functioning is the kind of information typically used by medical professionals to determine that the test results are not the best measure of a child’s day-to-day functioning. When SSA does not rely on test scores, it must explain the reasons for doing so in the case record or decision.³⁷

4. An Approach for Assessing Severity

The first step to assessing severity is to ensure that all evidence that rates the child’s functioning does so by comparing that child to other children who do not have medical impairments.

The first step is to ensure that all assessments of the child compare that child to other children of the same age without medical impairments. SSR 09-2p provides:

³³ 20 C.F.R. § 416.926a(e)(4)(ii)(B)

³⁴ 20 C.F.R. § 416.926a(e)(4)(iii).

³⁵ 20 C.F.R. § 416.926a(e)(4)(iii). The comments provide a different, and for advocates, better statement of this rule. The comments state that “it is primarily the responsibility of the person who administered the test to decide whether it reliably measures a child’s abilities.” 65 Fed. Reg. 54769.

³⁶ 20 C.F.R. § 416.926a(e)(4)(iii)(A).

³⁷ 20 C.F.R. § 416.926a(e)(4)(iii)(B).

Because we compare a child's functioning to the functioning of other children the same age who do not have impairments, we should understand the standard of comparison used by the sources of the information.

SSR 09-2p continues to note that a special education teacher could compare a child to other children in the child's special education class. That comparison is not helpful in determining severity of function limitation.

Certainly, in this context, standardized test results are useful indicators of rating severity because they are based on data drawn from all children of a certain age and the results reflect a comparison to children of the same age who do not have a medical impairment(s).

The second step is to review the evidence to determine whether "factors" have masked the severity of a child's limitations. SSA decision makers must consider, in assessing the severity of functional limitations, the amount of help or adaptations a child requires and the impact of structured or supportive settings. In so doing, decision makers are to consider the following: a) the range of activities a child does; b) the child's ability to do them independently, including any prompting the child requires to begin, carry through, and complete those activities; c) the pace at which the child does those activities; d) how much effort the child needs to do those activities; and e) how long the child is able to sustain such activities.³⁸ Based on that consideration, the decision maker must determine how that child would function without extra help, adaptations, or structured/supportive settings when compared to other children of the same age without medical impairment(s).

After these two steps are assessed, it is possible to detail the functional limitations of the child. SSR 09-1p provided a chart to show these limitations. With those limitations that have been normed to a) ensure that any comparisons in the evidence have been made to children of the same age without medical impairment(s); and b) that the masking effect of factors such as extra help, adaptations, and structured/supportive settings have been removed; the decisionmaker then asks the questions set forth in SSR 09-1p:

1. How many of the child's activities in the domain are limited (for example, one, few, several, many, or all)?
2. How important are the limited activities to the child's age-appropriate functioning (for example, basic, marginally important, or essential)?
3. How frequently do the activities occur and how frequently are they limited (for example, daily, once a week, or only occasionally)?
4. Where do the limitations occur (for example, only at home or in all settings)?

³⁸ 20 C.F.R. § 416.924a(b)(5).

