

Proposed Rules

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This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

SOCIAL SECURITY ADMINISTRATION

20 CFR Parts 404 and 416

[Docket No. SSA-2006-0114]

RIN 0960-AD78

Revised Medical Criteria for Evaluating Endocrine Disorders

AGENCY: Social Security Administration.

ACTION: Notice of proposed rulemaking.

SUMMARY: We propose to revise the criteria in the Listing of Impairments (the listings) that we use to evaluate claims under titles II and XVI of the Social Security Act (Act) involving endocrine disorders in adults and children. The proposed revisions reflect advances in medical knowledge, information we received from medical experts, comments we received from the public in response to an Advance Notice of Proposed Rulemaking (ANPRM) and at an outreach policy conference, and our adjudicative experience.

DATES: To ensure that your comments are considered, we must receive them by no later than February 12, 2010.

ADDRESSES: You may submit comments by any one of four methods—Internet, fax, mail, or hand-delivery. Do not submit the same comments multiple times or by more than one method. Regardless of which method you choose, please state that your comments refer to Docket No. SSA-2006-0114 so that we may associate your comments with the correct regulation.

Caution: You should be careful to include in your comments only information that you wish to make publicly available. We strongly urge you not to include in your comments any personal information, such as Social Security numbers or medical information.

1. *Internet:* We strongly recommend this method for submitting your comments. Visit the Federal eRulemaking portal at <http://www.regulations.gov>. Use the *Search* function of the webpage to find docket number SSA-2006-0114, then submit

your comment. Once you submit your comment, the system will issue you a tracking number to confirm your submission. You will not be able to view your comment immediately as we must manually post each comment. It may take up to a week for your comment to be viewable.

2. *Fax:* Fax comments to (410) 966-2830.

3. *Mail:* Address your comments to the Commissioner of Social Security, P.O. Box 17703, Baltimore, Maryland 21235-7703.

4. *Hand-delivery:* Deliver your comments to the Office of Regulations, Social Security Administration, 137 Altmeyer Building, 6401 Security Boulevard, Baltimore, MD 21235-6401, between 8 a.m. and 4:30 p.m., Eastern Time, business days.

Comments are available for public viewing on the Federal eRulemaking portal at <http://www.regulations.gov> or in person, during regular business hours, by arranging with the contact person identified below.

FOR FURTHER INFORMATION CONTACT: Judy Hicks, Office of Medical Listings Improvement, Social Security Administration, 6401 Security Boulevard, Baltimore, Maryland 21235-6401, (410) 965-1020. For information on eligibility or filing for benefits, call our national toll-free number, 1-800-772-1213, or TTY 1-800-325-0778, or visit our Internet site, Social Security Online, at <http://www.socialsecurity.gov>.

SUPPLEMENTARY INFORMATION:

Electronic Version

The electronic file of this document is available on the date of publication in the **Federal Register** at <http://www.gpoaccess.gov/fr/index.html>.

What revisions are we proposing?

We propose to:

- Revise and expand the introductory text to the endocrine body system for both adults (section 9.00) and children (section 109.00);
- Remove all of the current adult listings in the endocrine body system (listings 9.02-9.08); and
- Remove all of the current childhood listings in the endocrine body system (listings 109.02-109.13) and add a new listing 109.08 for children from birth to the attainment of age 6 who have

diabetes mellitus (DM) and require daily insulin.

If we publish these proposed rules as final rules, we will also publish a Social Security Ruling (SSR) that will provide more detailed information about specific endocrine disorders, the types of impairments that result from endocrine disorders, and how we will determine whether people who have endocrine disorders are disabled.

Why did we decide to propose these revisions?

These proposed revisions reflect advances in medical knowledge about evaluating and treating endocrine disorders, as well as our adjudicative experience. In developing these proposed rules, we used information from a variety of sources, including:

- Medical experts in the field of endocrinology, experts in other related fields, advocacy groups for people with DM, and people with endocrine disorders and their families;
- People who make disability determinations and decisions for us in State agencies and in our Office of Disability Adjudication and Review; and
- The published sources we list in the References section at the end of this preamble.

We received some of this information from public comments that responded to an ANPRM that we published in the **Federal Register** on August 11, 2005. 70 FR 46792. In the ANPRM, we announced our plans to update and revise this body system, and we invited interested people and organizations to send us written comments and suggestions. We also received public comments at an outreach policy conference on “Endocrine Disorders in the Disability Programs” that we hosted in Atlanta, GA on November 17, 2005.¹

Why are we proposing these revisions?

We last published final rules making comprehensive revisions to the

¹ Although we indicated in the ANPRM that we would not summarize or respond to the comments, we read and considered them carefully. You can read the ANPRM and the comments and suggestions we received at: <https://s044a90.ssa.gov/apps10/erm/rules.nsf/5da82b031a6677dc85256b41006b7f8d/6c2a08af38f947cd8525705a006cddf9!OpenDocument>. You can also read a transcript of the policy conference at the following link: http://www.ssa.gov/disability/Transcript-Endocrine_Disorder_Policy_Conference.pdf.

endocrine listings on December 6, 1985. 50 FR 50068. In the preamble to those rules, we indicated that we would periodically review and update the listings in light of medical advances in evaluating and treating endocrine disorders and our program experience. Since that time, however, we have generally only extended the effective date of the rules.²

When we originally published the endocrine disorders listings, we recognized that endocrine disorders could be of listing-level severity either alone or because of their effects on other body systems. Since 1985, medical science has made significant advances in detecting endocrine disorders at earlier stages, and newer treatments have resulted in better management of these conditions. For example:

- Pituitary gland disorders that suppress the production of antidiuretic hormones (current adult listing 9.05 and childhood listing 109.05) are now treated with replacement vasopressin (also called “antidiuretic hormone,” or ADH), which prevents diuresis (increased excretion of urine) and dehydration;

- Modern tests for hyperfunction of the adrenal cortex are more sensitive and accurate than the test required by current listing 109.06A, and provide better information for evaluating and controlling the symptoms and complications associated with this disorder; and

- Hormone deficiencies that affect the adrenal gland’s ability to produce cortisol and aldosterone (current adult listing 9.06 and childhood listings 109.07 and 109.11) are now treated with replacement drugs that control adrenal gland disorders.

Because of advances in medical treatment and detection, most endocrine disorders do not reach listing-level severity because they do not become sufficiently severe or do not remain at a sufficient level of severity long enough to meet our 12-month duration requirement. This is true even for people who have recurrent episodes of hypoglycemia or of diabetic acidosis (also called diabetic ketoacidosis, or DKA), a serious outcome of uncontrolled blood glucose levels. Current listings 9.08B and 109.08A, which provide criteria for people who have recurrent episodes of DKA, and listing 109.08B, which provides a

criterion for children who have recurrent episodes of hypoglycemia, reflect an earlier view that people with wide fluctuations in their blood glucose levels had uncontrollable DM. We consulted with endocrinologists, diabetologists, and other medical experts who treat DM, and they indicated that the current listings reflect only inadequate glucose regulation. The information we obtained from these experts and relevant medical references demonstrates that adequate glucose regulation is achievable with improved treatment options, such as a wider range of insulin products.

For these reasons, we believe that, with one exception, we should no longer have listings in sections 9.00 and 109.00 based on endocrine disorders alone, and we are proposing to remove all such current endocrine listings. The sole exception is for children under age 6 who have DM and require daily insulin. These children present a unique situation for which we are proposing a new listing, as we explain below.

Many of the current listings in the endocrine system are “reference listings”—listings that are met by satisfying the criteria of other listings. Endocrine glands regulate the functioning of organs and other glands, and endocrine disorders can cause problems that are of listing-level severity and that meet the duration requirement when they affect those organs or other glands. We evaluate these effects under other body system listings.³ For example, DM can lead to:

- Growth impairment in children, which we evaluate under the growth disorders listings in section 100.00;
- Amputations, which we evaluate under the musculoskeletal disorders listings in sections 1.00 and 101.00;
- Visual disorders, which we evaluate under the special senses and speech listings in sections 2.00 and 102.00;
- Cardiovascular disease, which we evaluate under the cardiovascular disorders listings in sections 4.00 and 104.00;
- Kidney disease, which we evaluate under the genitourinary disorders listings in sections 6.00 and 106.00;
- Neuropathies, which we evaluate under the neurological disorders listings in sections 11.00 and 111.00; and
- Clinical depression, which we evaluate under the mental disorders listings in sections 12.00 and 112.00.

The reference listings in sections 9.00 and 109.00 simply cross-refer to the

listings in other body systems appropriate for these impairments. For example, current listing 9.08C, for DM with retinitis proliferans (a visual disorder), cross-refers to listing 2.02, 2.03, or 2.04 in the special senses and speech body system. Listing 9.08C is redundant because we evaluate the visual effects of retinitis proliferans using listing 2.02, 2.03, or 2.04.⁴ We do not need any of the reference listings for endocrine disorders and we propose to remove them all. We have been removing reference listings from all of the body systems as we revise them, and the changes we are proposing in this NPRM are consistent with that approach.⁵

We considered whether we could propose revised criteria for the endocrine disorder listings instead of proposing to remove them all. We decided not to propose such criteria for two reasons. First, because the effects of the impairments vary too widely, we would not have been able to conclude that all people whose endocrine disorders met one of the alternative listings we considered would be unable to perform any gainful activity, the standard of severity we require for a listing. Second, some of the alternative listings we considered were so severe that people whose endocrine disorders would have met those criteria would also have impairments that met listings in other body systems. Therefore, such listings would have been unnecessary.

Why are we proposing to include guidance for evaluating endocrine disorders in sections 9.00 and 109.00 when there would be no endocrine disorders listings other than proposed listing 109.08?

Each body system is organized in two parts: an introduction, followed by specific listings. Sections 404.1525(c) and 416.925(c). In proposed section 9.00 (the adult listings), however, we are providing only the introduction in order to explain how we evaluate endocrine

² We published revisions to specific listings on July 2, 1993, August 24, 1999, and April 24, 2002. 58 FR 36008, 64 FR 46122, and 67 FR 20018. However, these revisions were not comprehensive. The current listings will no longer be effective as of July 1, 2010, unless we extend them. 73 FR 31025.

³ Some endocrine cancers result in death because of their direct effects on endocrine glands. We account for such impairments in the malignant neoplastic diseases sections of our listings, sections 13.00 and 113.00.

⁴ There are currently five reference listings in the endocrine system for adults and twelve reference listings in the endocrine system for children—9.02, 9.03B, 9.04C, 9.06, 9.08C, 109.02B2, 109.04B, 109.05C, 109.08C, 109.08D, 109.09B, 109.09C, 109.09D, 109.09E, 109.10, 109.11C, and 109.13. Eight of twelve childhood reference listings refer to listing 100.002A or B in the growth disorders listings, including listing 109.13, which refers to the criteria in “the appropriate body system.” Current adult listing 9.08A, although not technically a reference listing, contains identical criterion for peripheral neuropathy as in listing 11.14 in the neurological body system.

⁵ Examples of such recent changes include the “Revised Medical Criteria for Evaluating Digestive Disorders,” 72 FR 59398 (October 19, 2007), and the “Revised Medical Criteria for Evaluating Immune System Disorders,” 73 FR 14570 (March 18, 2008).

disorders and the impairments they may cause. We are not providing any specific listing criteria.⁶

We are proposing similar guidance in the introductory text of section 109.00 in the childhood endocrine listings. We also provide guidance on how we would evaluate disability claims for children whose DM does not meet proposed listing 109.08. We do not include guidance for evaluating the long-term complications of DM related to chronic hyperglycemia, as we do for adults in proposed section 9.00B5, because such complications are rare in children.

As we explain in the proposed sections 9.00C and 109.00D, endocrine-related impairments that do not meet or medically equal any listing may nonetheless result in a finding of disability for both adults and children. We may find adults to be disabled based on their residual functional capacity, age, education, and work experience. Sections 404.1520(g) and 416.920(g). We may find children who apply for SSI benefits to be disabled based on impairments that functionally equal the listings. Sections 416.924(d) and 416.926a.

Why are we proposing new listing 109.08 for children from birth to the attainment of age 6 who have DM and require daily insulin?

Careful monitoring of blood glucose levels is crucial to the health and survival of both adults and children with DM. Children under age 6 who have DM and require daily insulin to regulate glucose present a unique situation because they generally have not developed adequate cognitive capacity for recognizing and responding to hypoglycemic symptoms. To ensure the child's survival, an adult must monitor and supervise the child's insulin, food intake, and physical activity 24 hours a day to control the child's blood glucose level. This degree of help satisfies the fifth example of functional equivalence in the last paragraph of our functional equivalence regulation: the requirement for 24-hour-a-day supervision of a child for medical reasons. Section 416.926a(m)(5). Since listings are rules that we use to find disability in all people whose impairments meet their criteria, and since under functional equivalence example 5 all children under age 6 who have DM and require daily insulin are disabled, we believe it is simpler to provide a listing for these children.

Why are we not proposing a listing for children age 6 and older who have DM and require daily insulin, and how will we evaluate children of any age with DM who do not require daily insulin?

We are not proposing a listing for children age 6 and older who have DM and require daily insulin because many of these children do not have the same medical need for adult help as younger children. Generally, children develop the cognitive awareness needed to recognize the symptoms of hypoglycemia and to seek help by age 6. As they mature, they should also be able to increasingly take part in self-care activities, such as:

- Participating in blood glucose testing;
- Self-administering insulin;
- Interpreting blood glucose testing results;
- Determining proper dosages of multiple types of insulin;
- Following special diets and schedules for snacks and meals;
- Understanding the importance of engaging in recommended physical activities;
- Managing adjustments of insulin dosing and fluid intake in response to fluctuating glucose levels during acute illness; and
- Recognizing the importance of maintaining desirable glucose levels to prevent later complications.

Some of the children age 6 and older who have DM and require daily insulin will have impairments resulting from their DM that meet or medically equal listings in other body systems. Others will need the same level of help with their DM as children under age 6. We will find that those children have impairments that functionally equal the listings because they satisfy the functional equivalence example of a requirement for 24-hour-a-day supervision for medical reasons. Other children who do not need this level of help will nevertheless have impairments that functionally equal the listings pursuant to our rules for evaluating disability in children. Sections 416.926a and 416.924a.

The same is true for DM in a child of any age (that is, from birth to age 18) who does not require daily insulin. We will consider any impairment resulting from DM under the appropriate listing criteria in any affected body system. If the child's impairment or combination of impairments does not meet or medically equal a listing in any body system, we will determine whether the impairment(s) functionally equals the listings. Sections 416.924a and 416.926a.

Would our proposal to remove endocrine listings affect people who are already receiving benefits based on endocrine disorders?

If these rules become final, we will not terminate any person's disability benefits solely because we have removed any endocrine disorder listing, nor will we review prior allowances based on the endocrine disorders listings under the new rules. Unless we are otherwise required to do so (for example, by statute), we do not readjudicate previously decided cases when we revise our listings. We must periodically conduct continuing disability reviews to determine whether beneficiaries are still disabled. Sections 404.1589 and 416.989. When we do, we will not find that a person's disability has ended based on a change in a listing. In most cases, we must show that the person's impairment(s) has medically improved and that any medical improvement is "related to the ability to work." Sections 404.1594 and 416.994. Even where the impairment(s) has medically improved, our regulations provide that the improvement is not "related to the ability to work" if it continues to meet or medically equal the "same listing section used to make our most recent favorable decision." This is true even if we have deleted the listing section we used to make the most recent favorable decision. Sections 404.1594(c)(3)(i) and 416.994(b)(2)(iv)(A).⁷ When we find that medical improvement is not related to the ability to work (or, in the case of a person under age 18, the impairment still meets or medically equals the prior listing), we will find that disability continues, unless an exception to medical improvement applies.

What is our authority to make rules and set procedures for determining whether a person is disabled under the statutory definition?

Under the Act, we have full power and authority to make rules and regulations and to establish necessary and appropriate procedures to carry out such provisions. Sections 205(a), 702(a)(5), and 1631(d)(1).

How long would these proposed rules be effective?

If we publish these proposed rules as final rules, they will remain in effect for 8 years after the date they become effective, unless we extend them, or revise and issue them again.

⁶ We are proposing minor changes in our regulations to reflect this change. Sections 404.1525 and 416.925.

⁷ Our regulations contain a similar provision for continuing disability reviews for children eligible for SSI based on disability. See § 416.994a(b)(2).

Clarity of These Rules

Executive Order 12866 requires each agency to write all rules in plain language. In addition to your substantive comments on these proposed rules, we invite your comments on how to make them easier to understand.

For example:

- Would more, but shorter, sections be better?
- Are the requirements in the rules clearly stated?
- Have we organized the material to suit your needs?
- Could we improve clarity by adding tables, lists, or diagrams?
- What else could we do to make the rules easier to understand?
- Do the rules contain technical language or jargon that is not clear?
- Would a different format make the rules easier to understand, e.g. grouping and order of sections, use of headings, paragraphing?

When Will We Start To Use These Rules?

We will not use these rules until we evaluate public comments and publish final rules in the **Federal Register**. All final rules we issue include an effective date. We will continue to use our current rules until that date. If we publish final rules, we will include a summary of those relevant comments we received along with responses and an explanation of how we will apply the new rules.

Regulatory Procedures

Executive Order 12866

Note to reviewers: *This is a placeholder while we await program estimates.* We have consulted with the Office of Management and Budget (OMB) and determined that these proposed rules meet the requirements for a significant regulatory action under Executive Order 12866 and were subject to OMB review.

Regulatory Flexibility Act

We certify that these proposed rules would not have a significant economic impact on a substantial number of small entities because they affect only individuals. Therefore, a regulatory flexibility analysis is not required under the Regulatory Flexibility Act, as amended.

Paperwork Reduction Act

These proposed rules do not create any new or affect any existing collections and, therefore, do not require Office of Management and Budget approval under the Paperwork Reduction Act.

References

We consulted the following references when we developed these proposed rules:

- Anderson, Barbara and Richard L. Rubin, *Practical Psychology for Diabetes Clinicians: Effective Techniques for Key Behavioral Issues, 2nd Edition*, McGraw-Hill, New York (2003).
- Becker, Dorothy J. and Christopher M. Ryan, "Hypoglycemia in Children with Type 1 Diabetes Mellitus: Risk Factors, Cognitive Function, and Management," *Endocrinology and Metabolism Clinics*, Vol. 28, Issue 4, 883–900 (December 1999), available at: <http://www.mdconsult.com/das/article/body/94692077-2/jorg=journal&source=&sp=1158267&sid=0/N/158829/1.html>.
- Cooke, David W. and Leslie Plotnick, "Management of Diabetic Ketoacidosis in Children and Adolescents," *Pediatrics in Review, Pediatr. Rev.* 2008; 29; 431–436, available at: <http://pedsinreview.aappublications.org/cgi/content/full/29/12/431>.
- Cooke, David W. and Leslie Plotnick, "Type 1 Diabetes Mellitus in Pediatrics," *Pediatrics in Review, Pediatr. Rev.* 2008; 29; 374–385, available at: <http://pedsinreview.aappublications.org/cgi/content/full/29/11/374>.
- Cowell, Kristi M., "Focus on Diagnosis: Type 2 Diabetes Mellitus," *Pediatrics in Review, Pediatr. Rev.* 2008; 29; 289–292, available at: <http://pedsinreview.aappublications.org/cgi/content/full/29/8/289>.
- Feld, Stanley, "Medical Guidelines for the Management of Diabetes Mellitus: The AACE System of Intensive Diabetes Self Management—2002 Update," *The American Association of Clinical Endocrinologists, Endocrine Practice*, Vol. 8, Supplement, (January/February 2002), available at: http://www.gata.edu.tr/dahilibilimler/nefroloji/dosyalar/diabetes_2002.pdf.
- Johns Hopkins Hospital, "Type 2 Diabetes Drug Boom: Is Newer Better?" *The Johns Hopkins Medical Letter: Health After 50*, Vol. 19, No. 6 (August 2007).
- Kasper, D., *Endocrinology and Metabolism, Harrison's Principles of Internal Medicine, 16th Edition*, 2008–2299, McGraw-Hill Professional, New York (2004).
- Kliegman, Robert M., Richard E. Behrman, Hal B. Jensen, and Bonita F. Stanton, "The Endocrine System," *Nelson Textbook of Pediatrics, 18th Edition*, WB Saunders Co., Philadelphia, PA (2004).
- Silverstein, Janet, et al., "Care of Children and Adolescents with Type 1 Diabetes," *Diabetes Care*, Vol. 28, No. 1, 186–212, American Diabetes Association, Inc., Alexandria, VA (January 2005), available at: <http://care.diabetesjournals.org/cgi/reprint/28/1/186>.
- Social Security Administration, "Endocrine Disorders in the Disability Programs." Transcript of conference held in Atlanta, GA, November 17, 2005, available at: <http://www.ssa.gov/disability/Transcript->

Endocrine

- Disorder Policy Conference.pdf*.
- Sperling, Mark A., guest editor, "Diabetes Mellitus in Children," *Pediatric Clinics of North America*, Vol. 52, No. 6, 1533–1872 (December 2005), available at: http://www.mdconsult.com/das/article/body/94692077-4/jorg=journal&source=&sp=15876443&sid=0/N/505590/1.html?issn=0031-3955&issue_id=17939.
- Taras, Howard L., "The Role of the School Nurse in Providing School Health Services," Committee on School Health, American Academy of Pediatrics, *Pediatrics*, Vol. 108, No. 5, 1231–1232 (November 2001), available at: <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;108/5/1231.pdf>.

We will make these references available to you for inspection if you are interested in reading them. Please make arrangements with the contact person shown in this preamble if you would like to review any reference materials.

(Catalog of Federal Domestic Program Nos. 96.001, Social Security—Disability Insurance; 96.002, Social Security—Retirement Insurance; 96.004, Social Security—Survivors Insurance, and 96.006, Supplemental Security Income)

List of Subjects

20 CFR Part 404

Administrative practice and procedure; Blind, Disability benefits; Old-age, Survivors, and Disability Insurance; Reporting and recordkeeping requirements; Social Security.

20 CFR Part 416

Administrative practice and procedure; Blind; Disability benefits; Old age, Public assistance programs; Reporting and recordkeeping requirements; Supplemental Security Income (SSI).

Dated: September 10, 2009.

Michael J. Astrue,
Commissioner of Social Security.

For the reasons set out in the preamble, we propose to amend 20 CFR part 404 subpart P and part 416 subpart I as set forth below:

PART 404—FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE (1950–)

1. The authority citation for subpart P of part 404 continues to read as follows:

Authority: Secs. 202, 205(a), (b), and (d)—(h), 216(i), 221(a) and (i), 222(c), 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 405(a), (b), and (d)—(h), 416(i), 421(a) and (i), 422(c), 423, 425, and 902(a)(5)); sec. 211(b), Pub. L. 104–193, 110 Stat. 2105, 2189; sec. 202, Pub. L. 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

2. Amend § 404.1525 by revising paragraph (c)(1) and the first sentence of paragraph (c)(3) to read as follows:

§ 404.1525 Listing of impairments in appendix 1.

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(c) *How do we use the listings?* (1) Most body system sections in parts A and B of appendix 1 are in two parts: An introduction, followed by the specific listings.

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(3) In most cases, the specific listings follow the introduction in each body system, after the heading, *Category of Impairments*. * * *

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3. Amend appendix 1 to subpart P of part 404 by:

a. Revising item 10 of the introductory text before part A;

b. Revising the body system name for section 9.00 in the Part A table of contents;

c. Revising section 9.00 in part A;

d. Removing sections 9.01 through 9.08;

e. Revising the body system name for section 109.00 in the Part B table of contents; and

f. Revising section 109.00 in part B.

The revisions read as follows:

Appendix 1 to Subpart P of Part 404—Listing of Impairments

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10. Endocrine Disorders (9.00 and 109.00): [DATE 8 YEARS FROM THE EFFECTIVE DATE OF THE FINAL RULES].

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Part A

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9.00 Endocrine Disorders.

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9.00 Endocrine Disorders

A. What is an endocrine disorder?

An endocrine disorder is a medical condition that causes a hormonal imbalance. When an endocrine gland functions abnormally, producing either too much of a specific hormone (hyperfunction) or too little (hypofunction), the hormonal imbalance can cause various complications in the body. The major glands of the endocrine system are the pituitary, thyroid, parathyroid, adrenal, and pancreas.

B. How do we evaluate the effects of endocrine disorders? We evaluate impairments that result from endocrine disorders under the listings for other body systems. For example:

1. *Pituitary gland disorders* can disrupt hormone production and normal

functioning in other endocrine glands and in many body systems. The effects of pituitary gland disorders vary depending on which hormones are involved. For example, when pituitary hypofunction affects water and electrolyte balance in the kidney and leads to diabetes insipidus, we evaluate the effects of recurrent dehydration under 6.00.

2. *Thyroid gland disorders* affect the body's sympathetic nervous system and normal metabolism. We evaluate thyroid-related changes in blood pressure and heart rate that cause arrhythmias or other cardiac dysfunction under 4.00; thyroid-related weight loss under 5.00; hypertensive cerebrovascular accidents (strokes) under 11.00; and cognitive limitations, mood disorders, and anxiety under 12.00.

3. *Parathyroid gland disorders* affect calcium levels in bone, blood, nerves, muscle, and other body tissues. We evaluate parathyroid-related osteoporosis and fractures under 1.00; abnormally elevated calcium levels in the blood (hypercalcemia) that lead to cataracts under 2.00; kidney failure under 6.00; and recurrent abnormally low blood calcium levels (hypocalcemia) that lead to increased excitability of nerves and muscles, such as tetany and muscle spasms, under 11.00.

4. *Adrenal gland disorders* affect bone calcium levels, blood pressure, metabolism, and mental status. We evaluate adrenal-related osteoporosis with fractures that compromises the ability to walk or to use the upper extremities under 1.00; adrenal-related hypertension that worsens heart failure or causes recurrent arrhythmias under 4.00; adrenal-related weight loss under 5.00; and mood disorders under 12.00.

5. *Diabetes mellitus and other pancreatic gland disorders* disrupt the production of several hormones, including insulin, that regulate metabolism and digestion. Insulin is essential to the absorption of glucose from the bloodstream into body cells for conversion into cellular energy. The most common pancreatic gland disorder is *diabetes mellitus* (DM). There are two major types of DM: Type 1 and type 2. Type 1 DM—previously known as “juvenile diabetes” or “insulin-dependent diabetes mellitus” (IDDM)—is an absolute deficiency of insulin production that commonly begins in childhood and continues throughout adulthood. Treatment of type 1 DM always requires lifelong daily insulin. With type 2 DM—previously known as “adult-onset diabetes mellitus” or “non-insulin-dependent diabetes mellitus”

(NIDDM)—the body's cells resist the effects of insulin, impairing glucose absorption and metabolism. Treatment of type 2 DM generally requires lifestyle changes, such as increased exercise and dietary modification, and sometimes insulin in addition to other medications.

a. *Hyperglycemia*. Both types of DM cause hyperglycemia, which is an abnormally high level of blood glucose that may produce acute and long-term complications. Acute complications of hyperglycemia include diabetic ketoacidosis. Long-term complications of DM are related to chronic hyperglycemia.

i. *Diabetic ketoacidosis (DKA)*. DKA is a potentially life-threatening complication of DM in which the chemical balance of the body becomes dangerously hyperglycemic and acidic. It is an acute condition resulting from a severe insulin deficiency, which can occur due to missed or inadequate daily insulin therapy, or in association with an acute illness. It usually requires hospital treatment to correct the acute complications of dehydration, electrolyte imbalance, and insulin deficiency. You may have serious complications resulting from your treatment, which we evaluate under the affected body system. For example, we evaluate cardiac arrhythmias under 4.00, intestinal necrosis under 5.00, and cerebral edema and seizures under 11.00. Recurrent episodes of DKA may result from mood or eating disorders, which we evaluate under 12.00.

ii. *Chronic hyperglycemia*. Chronic hyperglycemia, which is longstanding abnormally high levels of blood glucose, leads to long-term diabetic complications by disrupting nerve and blood vessel functioning. This disruption can have many different effects in other body systems. For example, we evaluate diabetic peripheral neurovascular disease that leads to gangrene and subsequent amputation of an extremity under 1.00; diabetic retinopathy under 2.00; coronary artery disease and peripheral vascular disease under 4.00; diabetic gastroparesis that results in abnormal gastrointestinal motility under 5.00; diabetic nephropathy under 6.00; poorly healing bacterial and fungal skin infections under 8.00; diabetic peripheral and sensory neuropathies under 11.00; and cognitive impairments, depression, and anxiety under 12.00.

b. *Hypoglycemia*. People with DM may experience episodes of hypoglycemia, which is an abnormally low level of blood glucose. Most adults recognize the symptoms of hypoglycemia and reverse them by consuming substances containing

glucose. Severe hypoglycemia can lead to complications, including seizures or loss of consciousness, which we evaluate under 11.00, or altered mental status and cognitive deficits, which we evaluate under 12.00.

C. How do we evaluate endocrine disorders that do not have effects that meet or medically equal the criteria of any listing in other body systems? If your impairment(s) does not meet or medically equal a listing in another body system, you may or may not have the residual functional capacity to engage in substantial gainful activity. In this situation, we proceed to the fourth and, if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920. When we decide whether you continue to be disabled, we use the rules in §§ 404.1594, 416.994, and 416.994a.

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Part B

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109.00 Endocrine Disorders.

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109.00 Endocrine Disorders

A. What is an endocrine disorder?

An endocrine disorder is a medical condition that causes a hormonal imbalance. When an endocrine gland functions abnormally, producing either too much of a specific hormone (hyperfunction) or too little (hypofunction), the hormonal imbalance can cause various complications in the body. The major glands of the endocrine system are the pituitary, thyroid, parathyroid, adrenal, and pancreas.

B. How do we evaluate the effects of endocrine disorders? The only listing in this body system addresses children from birth to the attainment of age 6 who have diabetes mellitus (DM) and require daily insulin. We evaluate other impairments that result from endocrine disorders under the listings for other body systems. For example:

1. *Pituitary gland disorders* can disrupt hormone production and normal functioning in other endocrine glands and in many body systems. The effects of pituitary gland disorders vary depending on which hormones are involved. For example, when pituitary growth hormone deficiency in growing children limits bone maturation and results in pathological short stature, we evaluate under 100.00. When pituitary hypofunction affects water and electrolyte balance in the kidney and leads to diabetes insipidus, we evaluate the effects of recurrent dehydration under 106.00.

2. *Thyroid gland disorders* affect the body's sympathetic nervous system and

normal metabolism. We evaluate thyroid-related changes in linear growth under 100.00; thyroid-related changes in blood pressure and heart rate that cause cardiac arrhythmias or other cardiac dysfunction under 104.00; thyroid-related weight loss under 105.00; and cognitive limitations, mood disorders, and anxiety under 112.00.

3. *Parathyroid gland disorders* affect calcium levels in bone, blood, nerves, muscle, and other body tissues. We evaluate parathyroid-related osteoporosis and fractures under 101.00; abnormally elevated calcium levels in the blood (hypercalcemia) that lead to cataracts under 102.00; kidney failure under 106.00; and recurrent abnormally low blood calcium levels (hypocalcemia) that lead to increased excitability of nerves and muscles, such as tetany and muscle spasms, under 111.00.

4. *Adrenal gland disorders* affect bone calcium levels, blood pressure, metabolism, and mental status. We evaluate adrenal-related linear growth impairments under 100.00; adrenal-related osteoporosis with fractures that compromises the ability to walk or to use the upper extremities under 101.00; adrenal-related hypertension that worsens heart failure or causes recurrent arrhythmias under 104.00; adrenal-related weight loss under 105.00; and mood disorders under 112.00.

5. *Diabetes mellitus and other pancreatic gland disorders* disrupt the production of several hormones, including insulin, that regulate metabolism and digestion. Insulin is essential to the absorption of glucose from the bloodstream into body cells for conversion into cellular energy. The most common pancreatic gland disorder is *diabetes mellitus* (DM). There are two major types of DM: type 1 and type 2. Type 1 DM—previously known as “juvenile diabetes” or “insulin-dependent diabetes mellitus” (IDDM)—is an absolute deficiency of insulin secretion that commonly begins in childhood and continues throughout adulthood. Treatment of type 1 DM always requires lifelong daily insulin. With type 2 DM—previously known as “adult-onset diabetes mellitus” or “non-insulin-dependent diabetes mellitus” (NIDDM)—the body's cells resist the effects of insulin, impairing glucose absorption and metabolism. Although less common than type 1 DM in children, type 2 DM is increasingly being diagnosed prior to age 18. Treatment of type 2 DM generally requires lifestyle changes, such as increased exercise and dietary modification, and sometimes insulin in addition to other medications.

a. *Hyperglycemia.* Both types of DM cause hyperglycemia, which is an abnormally high level of blood glucose that may produce acute and long-term complications. Acute complications of hyperglycemia include diabetic ketoacidosis. Long-term complications of DM are related to chronic hyperglycemia, but are rare in children.

b. *Diabetic ketoacidosis (DKA).* DKA is a potentially life-threatening complication of DM in which the chemical balance of the body becomes dangerously hyperglycemic and acidic. It is an acute condition resulting from a severe insulin deficiency, which can occur due to missed or inadequate daily insulin therapy, or in association with acute illness. It usually requires hospital treatment to correct the acute complications of dehydration, electrolyte imbalance, and insulin deficiency. You may have serious complications resulting from your treatment, which we evaluate under the affected body system. For example, we evaluate cardiac arrhythmias under 104.00, intestinal necrosis under 105.00, and cerebral edema and seizures under 111.00. Recurrent episodes of DKA in adolescents may result from mood or eating disorders, which we evaluate under 112.00.

c. *Hypoglycemia.* Children with DM may experience episodes of hypoglycemia, which is an abnormally low level of blood glucose. Most children age 6 and older recognize the symptoms of hypoglycemia and reverse them by consuming substances containing glucose. Severe hypoglycemia can lead to complications, including seizures or loss of consciousness, which we evaluate under 111.00, or altered mental status, cognitive deficits, and permanent brain damage, which we evaluate under 112.00.

C. How do we evaluate DM in children?

Listing 109.08 is only for children with DM who have not attained age 6 and who require daily insulin. For all other children (that is, children with DM who are age 6 or older and require daily insulin, and children of any age with DM who do not require daily insulin), we determine if an impairment that results from DM, or a combination of impairments, meets or medically equals the criteria of a listing in another body system, or functionally equals the listings under the criteria in § 416.926a, considering the factors in § 416.924a. For example, a child age 6 or older who has a medical need for 24-hour-a-day adult supervision of insulin treatment, food intake, and physical activity to ensure survival will have an impairment

that functionally equals the listings based on the example in § 416.926a(m)(5).

D. How do we evaluate other endocrine disorders that have effects that do not meet or medically equal the criteria of any listing in other body systems? If your impairment(s) does not meet or medically equal a listing in another body system, we will consider whether your impairment(s) functionally equals the listings under the criteria in § 416.926a, considering the factors in § 416.924a. When we decide whether you continue to be disabled, we use the rules in § 416.994a.

109.01 *Category of Impairments, Endocrine.*

109.08 *Any type of diabetes mellitus in a child who requires daily insulin and has not attained age 6.* Consider under a disability until the attainment of age 6. Thereafter, evaluate the diabetes mellitus according to the rules in 109.00B5 and C.

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PART 416—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

4. The authority citation for subpart I of part 416 continues to read as follows:

Authority: Secs. 221(m), 702(a)(5), 1611, 1614, 1619, 1631(a), (c), (d)(1), and (p) and 1633 of the Social Security Act (42 U.S.C. 421(m), 902(a)(5), 1382, 1382c, 1382h, 1383(a), (c), (d)(1), and (p), and 1383(b); secs. 4(c) and 5, 6(c)–(e), 14(a), and 15, Pub. L. 98–460, 98 Stat. 1794, 1801, 1802, and 1808 (42 U.S.C. 421 note, 423 note, and 1382h note).

5. Amend § 416.925 by revising paragraph (c)(1) and the first sentence of paragraph (c)(3) to read as follows:

§ 416.925 Listing of impairments in appendix 1 of subpart P of part 404 of this chapter.

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(c) *How do we use the listings?* (1) Most body system sections in parts A and B of appendix 1 are in two parts: an introduction, followed by the specific listings.

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(3) In most cases, the specific listings follow the introduction in each body system, after the heading, *Category of Impairments*. * * *

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SOCIAL SECURITY ADMINISTRATION

20 CFR Parts 404 and 416

[Docket No. SSA–2009–0040]

RIN 0960–AF80

Revised Procedures and Criteria for Payment of Vocational Rehabilitation Services Under the Cost Reimbursement Program

AGENCY: Social Security Administration.

ACTION: Advance notice of proposed rulemaking.

SUMMARY: We are requesting your comments on whether and how we should revise our rules governing payment for vocational rehabilitation (VR) services under the cost reimbursement program. Our current regulations do not reflect programmatic changes resulting from the new regulations we issued in May of 2008 for the Ticket to Work and Self-Sufficiency Program (Ticket to Work program). We are requesting your comments as part of our ongoing effort to ensure that the regulations governing cost reimbursement for VR services are current and support our other return to work programs, specifically the Ticket to Work and Work Incentive programs. If we propose specific revisions, we will publish a Notice of Proposed Rulemaking in the **Federal Register**.

DATES: To ensure that we consider your comments, we must receive them no later than February 12, 2010.

ADDRESSES: You may submit comments by any one of three methods—Internet, fax, or mail. Do not submit the same comments multiple times or by more than one method. Regardless of which method you choose, please state that your comments refer to Docket No. SSA–2009–0040 so that we may associate your comments with the correct regulation.

Caution: You should be careful to include in your comments only information that you wish to make publicly available. We strongly urge you not to include in your comments any personal information, such as Social Security numbers or medical information.

1. **Internet:** We strongly recommend this method for submitting your comments. Visit the Federal eRulemaking portal at <http://www.regulations.gov>. Use the *Search* function of the webpage to find docket number SSA–2009–0040, then submit your comment. Once you submit your comment, the system will issue you a tracking number to confirm your submission. You will not be able to

view your comment immediately as we must manually post each comment. It may take up to a week for your comment to be viewable.

2. **Fax:** Fax comments to (410) 966–2830.

3. **Mail:** Mail your comments to the Office of Regulations, Social Security Administration, 137 Altmeyer Building, 6401 Security Boulevard, Baltimore, Maryland 21235–6401.

Comments are available for public viewing on the Federal eRulemaking portal at <http://www.regulations.gov> or in person, during regular business hours, by arranging with the contact person identified below.

FOR FURTHER INFORMATION CONTACT: Brian Rudick, Office of Regulations, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–7105. For information on eligibility or filing for benefits, call our national toll-free number, 1–800–772–1213 or TTY 1–800–325–0778, or visit our Internet site, Social Security Online, at <http://www.socialsecurity.gov>.

SUPPLEMENTARY INFORMATION:

Electronic Version

The electronic file of this document is available on the date of publication in the **Federal Register** at <http://www.gpoaccess.gov/fr/index.html>.

What Is The Purpose of This Advance Notice of Proposed Rulemaking (ANPRM)?

This ANPRM gives you an opportunity to provide input concerning whether and how we might revise our procedures and criteria for payments to State VR agencies for VR services provided to disability beneficiaries under the cost reimbursement system. The regulations governing State VR agency cost reimbursement are found in 20 CFR part 404, subpart V, and part 416, subpart V. We last published rules for this program in the **Federal Register** on July 7, 2003. We are publishing this ANPRM as part of our ongoing effort to ensure that our criteria are effective and provide accurate guidance regarding the connection between the VR cost reimbursement and Ticket to Work programs.

On Which Rules Are We Inviting Comments?

We are interested in any comments and suggestions you have about how we should revise 20 CFR part 404, subpart V, and part 416, subpart V. You can find the current rules for the cost reimbursement program on the Internet at the following locations: