impact on a substantial number of small entities. The Small Business Administration's Office of Size Standards develops the numerical definition of a small business.[34] For electric utilities, a firm is small if, including its affiliates, it is primarily engaged in the transmission, generation and/or distribution of electric energy for sale and its total electric output for the preceding twelve months did not exceed four million megawatt hours. The Commission does not expect the proposed remand discussed herein to materially change the cost for small entities to comply with BAL–002–1. Therefore, the Commission certifies that the proposed rule will not have a significant economic impact on a substantial number of small entities.

VII. Comment Procedures

28. The Commission invites interested persons to submit comments on the matters and issues proposed in this notice to be adopted, including any related matters or alternative proposals that commenters may wish to discuss. Comments are due July 8, 2013. Comments must refer to Docket No. RM13–6–000, and must include the commenter's name, the organization they represent, if applicable, and their address in their comments.

29. The Commission encourages comments to be filed electronically via the eFiling link on the Commission's Web site at *http://www.ferc.gov.* The Commission accepts most standard word processing formats. Documents created electronically using word processing software should be filed in native applications or print-to-PDF format and not in a scanned format. Commenters filing electronically do not need to make a paper filing.

30. Commenters that are not able to file comments electronically must send an original and 14 copies of their comments to: Federal Energy Regulatory Commission, Secretary of the Commission, 888 First Street NE., Washington, DC 20426.

31. All comments will be placed in the Commission's public files and may be viewed, printed, or downloaded remotely as described in the Document Availability section below. Commenters on this proposal are not required to serve copies of their comments on other commenters.

VIII. Document Availability

32. In addition to publishing the full text of this document in the **Federal Register,** the Commission provides all interested persons an opportunity to view and/or print the contents of this document via the Internet through the Commission's Home Page (*http://www.ferc.gov*) and in the Commission's Public Reference Room during normal business hours (8:30 a.m. to 5:00 p.m. Eastern time) at 888 First Street NE., Room 2A, Washington DC 20426.

33. From the Commission's Home Page on the Internet, this information is available on eLibrary. The full text of this document is available on eLibrary in PDF and Microsoft Word format for viewing, printing, and/or downloading. To access this document in eLibrary, type the docket number excluding the last three digits of this document in the docket number field.

34. User assistance is available for eLibrary and the Commission's Web site during normal business hours from the Commission's Online Support at (202) 502–6652 (toll free at 1–866–208–3676) or email at *ferconlinesupport@ferc.gov,* or the Public Reference Room at (202) 502–8371, TTY (202) 502–8659. Email the Public Reference Room at *public.referenceroom@ferc.gov.*

By direction of the Commission.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2013–12131 Filed 5–21–13; 8:45 am]

BILLING CODE 6717–01–P

[34] *See* 13 CFR 121.201.

SOCIAL SECURITY ADMINISTRATION

20 CFR Parts 404 and 416

[Docket No. SSA–2011–0081]

RIN 0960–AG28

Revised Listings for Growth Disorders and Weight Loss in Children

AGENCY: Social Security Administration.

ACTION: Notice of proposed rulemaking.

SUMMARY: Several body systems in our Listing of Impairments (listings) contain listings for children based on impairment of linear growth or weight loss. We propose to replace those listings with new listings, add a listing to the genitourinary body system for children, and provide new introductory text for each listing explaining how to apply the new criteria. The proposed revisions to our listings reflect our program experience, advances in medical knowledge, comments we received from medical experts and the public at an outreach policy conference, and comments we received in response to a notice of intent to issue regulations and request for comments (request for comments) and an advance notice of proposed rulemaking (ANPRM). We are also proposing conforming changes in our regulations for title XVI of the Social Security Act (Act).

DATES: To ensure that your comments are considered, we must receive them by no later than July 22, 2013.

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–2011–0081 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 that you submit your comments via the Internet. Please visit the Federal eRulemaking portal at *http://www.regulations.gov.* Use the *Search* function to find docket number SSA–2011–0081. The system will issue a tracking number to confirm your submission. You will not be able to view your comment immediately because we must post each comment manually. 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 Office of Regulations and Reports Clearance, Social Security Administration, 107 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: Cheryl A. Williams, 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:

What revisions are we proposing?

We propose to:

• Comprehensively revise 100.00, the Growth Impairment body system for children. We would apply the new listings in the body system only to infants who were born with low birth weight and to children who have not attained age 3 who fail to grow at the expected rate and have developmental delay (failure to thrive or FTT) as a listing level condition. We would no longer have impairment listings for linear growth alone.

• Revise listing 105.08 in the Digestive System. We would replace references to measurements on the latest versions of the Centers for Disease Control and Prevention's (CDC) growth charts with weight-for-length growth tables that we currently use for children from birth to attainment of age 2, and the body mass index (BMI)-for-age growth tables that we currently use for children age 2 to attainment of age 18. We would also provide more detailed listing criteria and guidance for applying the revised listing.

• Revise listings in the respiratory, cardiovascular, and immune systems that refer to the CDC's or other growth charts to incorporate the tables and other criteria we are proposing for listing 105.08. We would also refer to the tables in proposed listing 105.08 in one of the listings we are proposing for growth failure in children. In addition, we propose to add a listing in the Genitourinary Impairments body system similar to the listings in the other body systems.

• Revise the introductory text and listings to use the term ''growth failure'' for the body systems with growth listings. Our program experience shows that we are more likely to see the term ''growth failure'' in medical evidence than other terms now in our listings. The term ''growth failure'' includes impairment of linear and weight growth.

Why are we proposing these revisions?

We propose these revisions to reflect medical advances and our program experience. We last published final rules making comprehensive revisions to the growth section for children (people under age 18), section 100.00, on December 6, 1985.[1] We last published final rules revising 105.08 in the digestive system on October 19, 2007.[2] In the preamble to those rules, we indicated that we would periodically review and update the listings in light of our program experience and medical advances. Since that time, however, we have only extended the effective date of the rules.[3]

How did we develop these proposed revisions?

In developing these proposed revisions, we considered public comments received in response to the request for comments and the ANPRM we published in the **Federal Register** on June 14, 2000 and September 8, 2005.[4] In the request for comments and ANPRM, we announced our plans to update and revise the growth impairment listings, and we invited interested parties to send us written comments and suggestions.[5] On November 18, 2005, we hosted a policy outreach conference on ''Growth Disorders in the Disability Programs'' in Atlanta, Georgia.[6] From August 25 through 26, 2005, we hosted a policy outreach conference on ''Respiratory Disorders in the Disability Programs'' in Chicago, Illinois.[7] We also considered the Institute of Medicine consensus report, *HIV and Disability: Updating the Social Security Listings,* in setting CD4 values in combination with growth failure in children.[8]

We also considered information from a variety of sources, including:

• Individual medical experts in the field of growth and development, experts in related fields, representatives from advocacy groups for people with growth and developmental disorders, and people with growth and developmental disorders;

• People who make and review disability determinations and decisions for us in State agencies, in our Office of Quality Performance, 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.

What revisions are we proposing and why are we proposing them?

Current section 100.00, Growth Impairment

We propose to change the name of this section to ''Low Birth Weight and Failure to Thrive'' to reflect the proposed changes to the listings. We also propose to revise the introductory text to reflect that we no longer use linear growth alone in the proposed listings. The proposed introductory text explains the conditions we evaluate in this section and provides guidance on how to apply the proposed listings.

Additionally, we propose to explain in section 100.00C.2.d that under listing 100.05A for growth failure, any measurements taken before the child attains age 2 can be used to evaluate the impairment under the appropriate listing for the child's age. These measurements must be taken within a 12-month period and be at least 60 days apart. A child who attains age 3 could no longer be evaluated under these listings. However, the measurements could be used to evaluate the child's impairment under the most affected body system.

Current Listings 100.02 and 100.03, Growth Impairment

We propose to delete these listings because they are based on linear (height) growth alone. Our adjudicative experience has shown that a declining linear growth rate is not always indicative of a disabling condition and that short stature in itself is not disabling.

Proposed Listing 100.04, Low Birth Weight in Infants From Birth To Attainment of Age 1

We currently find low birth weight (LBW) infants disabled until the attainment of age 1 under examples 6 and 7 in our functional equivalence rule.[9] We believe that it is simpler to provide a listing for these children. In example 6, we currently find infants from birth to the attainment of age 1 whose birth weight satisfy the objective criteria to be disabled. In example 7, we currently find children whose birth

[1] 50 FR 50068.

[2] 72 FR 59398.

[3] We published technical revisions to the listings on April 24, 2002. 67 FR 20018. These revisions included changes to the growth impairment and digestive system listings for children, but the revisions were not comprehensive. We extended the expiration date of the current listings for several body systems, including the growth impairment and digestive system listings, in final rules published on June 13, 2012. 77 FR 35264. The final rules extended the date on which the current growth impairment listings will no longer be effective to July 1, 2014 and the date on which the current digestive system listings will no longer be effective to April 1, 2014. 77 FR 35265.

[4] June 14, 2000 (65 FR 37321) and September 8, 2005 (70 FR 53323).

[5] Although we indicated that we would not summarize or respond to the comments, we read and considered them carefully. You can read the September 8, 2005 ANPRM and the comments we received in response to the ANPRM at *http://www.regulations.gov.* Use the *Search* function to find docket number SSA–2006–0181. You can read the June 14, 2000 request for comments at *https://federalregister.gov/a/00-14841.*

[6] You can read a transcript of the policy conference at *http://www.regulations.gov.* Use the *Search* function to find document ID number SSA–2006–0181–0002.

[7] You can read the transcript of the policy conference at *http://www.regulations.gov.* Use the *Search* function to find document ID number SSA–2006–0149–0002.

[8] Institute of Medicine. (2010). *HIV and disability: Updating the Social Security Listings.* Washington, DC: The National Academies Press.

[9] See § 416.926a(m)(6) and (m)(7).

weight and gestational age satisfy the objective criteria to be disabled.

We also propose to provide a table of gestational ages and birth weights that will help adjudicators determine when an infant's birth weight, in combination with his or her gestational age, meets the criteria for LBW under the proposed listing.

We would explain in proposed 100.00B that, for impairments that meet the requirements in proposed listing 100.04A or 100.04B, we would follow the guidance in our regulations for considering LBW claims for medical reviews.[10]

Proposed Listing 100.05, Failure To Thrive in Children From Birth To Attainment Of Age 3

We currently provide guidance in our operating instructions for adjudicators to evaluate failure to thrive (FTT) in children from birth to attainment of age 2 under 105.08, the listing for malnutrition due to a digestive disorder.[11] If the child does not have a digestive disorder, we determine whether the child's growth disorder medically equals the digestive listing. This determination can be especially difficult when there are no identifiable or distinctive physical findings related to the child's FTT that an adjudicator could compare to the nutritional deficiency findings required in 105.08A. We are proposing listing 100.05 in which we would evaluate FTT in children from birth to attainment of age 3 regardless of whether there is a known cause for the child's growth failure.

Under our program rules, FTT can be a medically determinable impairment because it results from anatomical, physiological, or psychological abnormalities shown by medically acceptable clinical and laboratory diagnostic techniques. There is, however, no single definition or description of FTT. Medical sources reference various growth charts and growth percentiles for establishing FTT. Some medical sources establish a diagnosis of FTT based on the child's growth failure and various degrees of developmental delay. Others establish FTT based on growth failure alone. In proposed 100.05, we would require documentation of both growth failure and developmental delay to establish FTT as a listing-level condition because our program experience has shown that growth failure alone is not disabling.

In proposed 100.05A, we would evaluate growth failure by using the appropriate table(s) under proposed 105.08B in the digestive system to determine whether a child's growth is less than the third percentile. We would require three weight-for-length measurements for children from birth to attainment of age 2 or three body mass index (BMI)-for-age measurements for children age 2 to attainment of age 3 that are within a consecutive 12-month period and at least 60 days apart. If a child attains age 2 during the adjudication period, measurements taken before the child attains age 2 can be used to evaluate the impairment under the appropriate listing for the child's age, if the measurements were obtained within a 12-month period and are at least 60 days apart. We believe this number and interval of measurements over a consecutive 12-month period would establish that an infant's or a toddler's rate of growth reflects actual growth failure and not a short-term delay in rate of growth. This guidance on growth measurements apply to all affected body systems. The child does not have to have a digestive disorder for the purposes of proposed 100.05.

In proposed 100.05B, we would require a report from an acceptable medical source that establishes the appropriate level of delay in a child's development. Acceptable medical sources or early intervention specialists, physical or occupational therapists, and other sources may conduct standardized developmental assessments and developmental screenings.[12] The results of these tests and screenings must include a statement or records from an acceptable medical source indicating the child has a developmental delay. We would document the severity of the developmental delay with test results from a standardized developmental assessment that compares a child's level of development to the level typically expected for his or her chronological age. The required level of severity would be met if the test results indicate that the child's development is not more than two-thirds of the level typically expected for the child's age or results in a valid score that is at least two standard deviations below the mean.

In proposed 100.05C, we would require developmental delay established by an acceptable medical source and documented by findings from two narrative developmental reports dated at least 120 days apart that indicate development not more than two-thirds of the level typically expected for a child's age. We would require the narrative report to include the child's developmental history, physical examination findings, and an overall assessment of the child's development (that is, more than one or two isolated skills) by the acceptable medical source. Abnormal findings noted on repeated examinations, and information in narrative developmental reports, that may include the results of developmental screening tests, can identify a child who is not developing or achieving skills within expected timeframes.

Our current operating instructions limit evaluation of FTT to children from birth to attainment of age 2. We would extend the age limit in the proposed listing because our adjudicative experience indicates that FTT may continue to attainment of age 3. Our adjudicative experience has been that, by age 3, most children who develop or continue to experience growth failure will have an identifiable cause for their growth failure, which we evaluate under the affected body system.

Proposed Listing 103.06, Growth Failure Due to Any Chronic Respiratory Disorder

We propose to add 103.06, under the respiratory body system, for evaluating growth failure in children with chronic respiratory disorders because growth failure is a common complication of chronic respiratory disorders in children. We would add the same growth failure criteria as proposed in 105.08B. We would also provide guidance in the introductory text to adjudicators on how to evaluate growth failure under the proposed listing.

Proposed Listing 104.02C

We propose to revise 104.02C, under the cardiovascular body system, to conform to criteria we are proposing to growth listings in other body systems. We also propose to change the current title of the listing from *Growth disturbance with* to *Growth failure as required in 1 or 2.* We would add the same growth failure criteria as proposed in 105.08B. We would also provide guidance in the introductory text on how to evaluate growth failure under the proposed listing.

Proposed Listing 105.08, Growth Failure Due to Any Digestive Disorder

We propose to revise the title of listing 105.08, under the digestive body system, to change *Malnutrition due to any digestive disorder* to *Growth failure due to any digestive disorder.* We would provide guidance in the introductory text on how to evaluate growth failure under the proposed listing.

[10] See § 416.990(b)(11).

[11] POMS DI 24550.001 at *https://secure.ssa.gov/poms.nsf/lnx/0424550001.*

[12] See, §§ 404.1513(a) and 416.913(a).

We propose to revise the current criteria in 105.08A. We would require two laboratory values at least 60 days apart within a consecutive 12-month period instead of a consecutive 6-month period to be consistent with pediatric standards of care for evaluating growth over time. We would remove the phrase ''despite continuing treatment as prescribed'' because we address the issue of following prescribed treatment elsewhere in our rules.[13] We would also remove current 105.08A3 because the criterion is no longer a good indicator of nutritional deficiency. As a result of advances in medical therapy, the vitamin or mineral deficiencies referred to in the current listing can be supplemented in the diet.

We would change the title of 105.08B from *Growth retardation documented by one of the following* to *Growth failure as required in 1 or 2.* We would also require at least 60 days between the growth measurements to be consistent with similar rules in other body systems.

In proposed 105.08B, we would add the weight-for-length growth tables that we currently use for children from birth to attainment of age 2, and the body mass index (BMI)-for-age growth tables that we use for children age 2 to attainment of age 18, both of which are in our current operating instructions for determining growth failure.[14] We would no longer refer adjudicators to the Centers for Disease Control and Prevention's (CDC's) latest recommended growth charts. In making this proposed change, we considered the CDC's recently published revised growth charts for children that adopt the World Health Organization (WHO) standards for monitoring growth in children birth to age 2.[15] There are several reasons why we did not adopt these growth charts for purposes of evaluating growth under our listings. The WHO's growth charts use a 2.3 percentile standard to represent two standard deviations below the mean and describe the growth of healthy children in optimal conditions. However, we currently evaluate growth failure based on growth measurements that are less than the 3.0 or third percentile of the tables in our current operating instructions to represent two standard deviations below the mean. Additionally, the 3.0 or third percentile based on the WHO's growth charts would identify fewer children than our current third percentile tables, which we base on CDC's growth charts prior to their adoption of the WHO recommended growth standards.

The third percentile BMI-for-age tables we propose to add to listing 105.08B for children age 2 to attainment of age 18 are based on CDC's current BMI-for-age growth charts. We propose adding the third percentile tables in 105.08B instead of growth charts because, in our adjudicative experience, we have found that plotted growth charts are not always included in a child's medical records whereas weight and length or weight measurements are. It is also simpler for our adjudicators to apply the measurements to the third percentile tables rather than plotting measurements themselves on a growth chart. Using weight-for-length measurements also means that adjudicators do not need to adjust for prematurity.

We believe that it remains programmatically correct for us to continue to determine growth failure for children from birth to attainment of age 18 using the tables currently in our operating instructions. We believe that children who have growth measurements that are less than the third percentile, and have another impairment with marked limitations as described in each of the proposed listings containing growth criteria, are disabled.

Proposed Listing 106.08, Growth Failure Due to Any Chronic Renal Disease

We propose to add 106.08, under the genitourinary body system, for evaluating growth failure in children with chronic renal disease because growth failure is a common complication of chronic renal disease in children. The kidneys regulate the amounts and interactions of nutrients, including proteins, minerals, and vitamins, necessary for growth. Impaired kidney function and the side effects of treatment may decrease a child's appetite and further limit the utilization of these nutrients, resulting in growth failure. We would add the same growth failure criteria as proposed in 105.08B. We would also provide guidance in the introductory text on how to evaluate growth failure under the proposed listing.

Proposed Listing 114.08H, Immune Suppression and Growth Failure

We propose to revise 114.08H, under the immune body system, for children with growth failure due to HIV-induced immune suppression to conform to criteria we are proposing for growth listings in other body systems. We would remove the current weight-loss criteria and add laboratory criteria and the same growth failure criteria as proposed in 105.08B. We propose to quantify the degree of HIV-induced immune suppression by specifying CD4 laboratory criteria for different ages, following accepted medical standards of care. We would also provide guidance in the introductory text on how to evaluate growth failure under the proposed listing.

Other Changes

We also propose the following conforming changes:

- Revise § 416.924b(b) to reflect the removal of listings 100.002 and 100.03 and the addition of 100.04;
- Revise § 416.926a(m) by removing examples 6 and 7 for children with low birth weight because we are providing listings with these specific criteria; and
- Revise § 416.934 [16] by adding two presumptive disability categories for infants with low birth weight. This revision reflects our longstanding operational instructions for making findings of presumptive disability for such infants.

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 5 years after the date they become effective unless we extend them or revise and issue them again.

Clarity of These Proposed Rules

Executive Order 12866, as supplemented by Executive Order 13563, requires each agency to write all rules in plain language. In addition to your substantive comments on these

[13] See § 416.930.

[14] POMS DI 24550.001 Weight-for-Length Table (Birth to the Attainment of Age 2) at *http://policynet.ba.ssa.gov/poms.nsf/lnx/0424550001.and* POMS DI 24550.002 Body-Mass-Index-for-Age Tables (Age 2 to the Attainment of Age 18) at *https://secure.ssa.gov/apps10/poms.nsf/lnx/0424550002.*

[15] The CDC's Growth Charts at *http://www.cdc.gov/growthcharts/.*

[16] Section 416.934 provides a list of impairment categories that employees in our field offices may use to make findings of presumptive disability in SSI claims without obtaining any medical evidence. We may make SSI payments based on presumptive disability or presumptive blindness when there is a high probability that we will find a claimant disabled or blind when we make our formal disability determination at the initial level of our administrative review process. § 416.933.

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, as Supplemented by Executive Order 13563

We consulted with the Office of Management and Budget (OMB) and determined that these proposed rules meet the criteria for a significant regulatory action under Executive Order 12866, as supplemented by Executive Order 13563. Therefore, OMB reviewed them.

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 individuals only. 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:

Cole, C., Binney, G., Casey, P., Fiascone, J., Hagadorn, J., & Kim, C. (2002). Criteria for determining disability in infants and children: Low birth weight. *Evidence Reports/Technology Assessments, 70*(1), (AHRQ Publication No. 03–E010). Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from *http://www.ahrq.gov/downloads/pub/evidence/pdf/lbw/lbw.pdf*

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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 Assistance 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; Aged, Blind, Disability benefits; Public assistance programs; Reporting and recordkeeping requirements; Supplemental Security Income (SSI).

Dated: May 9, 2013.

Carolyn W. Colvin,

Acting 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–)

Subpart P—[Amended]

■ 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), (i), and (j), 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), (i), and (j), 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 appendix 1 to subpart P of part 404 by revising item 1 of the introductory text before part A of appendix 1, and in part B of appendix 1 by:

■ a. Revising the body system name for section 100.00 in the table of contents,

■ b. Revising section 100.00,

■ c. Adding section 103.00F,

■ d. Adding listing 103.06,

■ e. Revising section 104.00C2b,

■ f. Revising section 104.00C2bii,

■ g. Adding section 104.00C3,

■ h. Revising listing 104.02C,

■ i. Revising section 105.00G,

■ j. Revising listing 105.08,

■ k. Adding section 106.00E5,

■ l. Adding listing 106.08,

■ m. Adding section 114.00F4, and

■ n. Revising listing 114.08H,

The revisions and additions read as follows:

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

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1. Low Birth Weight and Failure To Thrive (100.00): [DATE 5 YEARS FROM THE EFFECTIVE DATE OF THE FINAL RULE].

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Part B

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100.00 Low Birth Weight and Failure To Thrive.

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100.00 LOW BIRTH WEIGHT AND FAILURE TO THRIVE

A. *What conditions do we evaluate under these listings?* We evaluate low birth weight (LBW) in infants from birth to attainment of age 1 and failure to thrive (FTT) in infants and toddlers from birth to attainment of age 3.

B. *How do we evaluate disability based on LBW under 100.04?* In 100.04A and 100.04B, we use an infant's birth weight as documented by an original or certified copy of the infant's birth certificate or by a medical record signed by a physician. *Birth weight* means the first weight recorded after birth. In 100.04B, *gestational age* is the infant's age based on the date of conception as recorded in the medical record. If your impairment meets the requirements for listing 100.04A or 100.04B, we will follow the rules in § 416.990(b)(11) of this chapter.

C. *How do we evaluate disability based on FTT under 100.05?*

1. *General.* We establish FTT with or without a known cause when we have documentation of an infant's or a toddler's growth failure and developmental delay from an acceptable medical source(s) as defined in § 416.913(a) of this chapter. We require documentation of growth measurements in 100.05A and developmental delay described in 100.05B or 100.05C within the same consecutive 12-month period. The dates of developmental testing and reports may be different from the dates of growth measurements. After the attainment of age 3, we evaluate growth failure under the affected body system(s).

2. *Growth failure.* Under 100.05A, we use the appropriate table(s) under 105.08B in the digestive system to determine whether a child's growth is less than the third percentile. The child does not need to have a digestive disorder for purposes of 100.05.

a. For children from birth to attainment of age 2, we use the weight-for-length table corresponding to the child's gender (Table I or Table II).

b. For children age 2 to attainment of age 3, we use the body mass index (BMI)-for-age table corresponding to the child's gender (Table III or Table IV).

c. BMI is the ratio of a child's weight to the square of his or her height. We calculate BMI using the formulas in 105.00G2c.

d. *Growth measurements.* The weight-for-length measurements for children birth to the attainment of age 2 and body mass index (BMI)-for-age measurements for children age 2 to attainment of age 3 that are required for this listing must be obtained within a 12-month period and at least 60 days apart. If a child attains age 2 during the evaluation period additional measurements are not needed. Any measurements taken before the child attains age 2 can be used to evaluate the impairment under the appropriate listing for the child's age. If the child attains age 3 during the evaluation period, the measurements can be used to evaluate them in the most affected body system.

3. *Developmental delay.*

a. Under 100.05B and C, we use reports from acceptable medical sources to establish delay in a child's development.

b. Under 100.05B, we document the severity of developmental delay with results from a standardized developmental assessment, which compares a child's level of development to the level typically expected for his or her chronological age. If the child was born prematurely, we may use the corrected chronological age (CCA) for comparison. (See § 416.924b(b) of this chapter.) CCA is the chronological age adjusted by a period of gestational prematurity. CCA = (chronological age) − (number of weeks premature). Acceptable medical sources or early intervention specialists, physical or occupational therapist, and other sources may conduct standardized developmental assessments and developmental screenings. The results of these tests and screenings must be accompanied by a statement or records from an acceptable medical source who established the child has a developmental delay.

c. Under 100.05C, when there are no results from a standardized developmental assessment in the case record, we need narrative developmental reports from the child's medical sources in sufficient detail to assess the severity of his or her developmental delay. A narrative developmental report is based on clinical observations, progress notes, and well-baby check-ups. To meet the requirements for 100.05C, the report must include: the child's developmental history; examination findings (with abnormal findings noted on repeated examinations); and an overall assessment of the child's development (that is, more than one or two isolated skills) by the medical source. Some narrative developmental reports may include results from developmental screening tests, which can identify a child who is not developing or achieving skills within expected timeframes. Although medical sources may refer to screening test results as supporting evidence in the narrative developmental report, screening test results alone cannot establish a diagnosis or the severity of developmental delay.

D. *How do we evaluate disorders that do not meet one of these listings?*

1. We may find infants disabled due to other disorders when their birth weights are greater than 1200 grams but less than 2000 grams and their weight and gestational age do not meet 100.04. The most common disorders of prematurity and LBW include retinopathy of prematurity (ROP), chronic lung disease of infancy (CLD, previously known as bronchopulmonary dysplasia, or BPD), intraventricular hemorrhage (IVH), necrotizing enterocolitis (NEC), and periventricular leukomalacia (PVL). Other disorders include poor nutrition and growth failure, hearing disorders, seizure disorders, cerebral palsy, and developmental disorders. We evaluate these disorders under the affected body systems.

2. We may evaluate infants and toddlers with growth failure that is associated with a known medical disorder under the body system of that medical disorder, for example, the respiratory or digestive body systems.

3. If an infant or toddler has a severe medically determinable impairment(s) that does not meet the criteria of any listing, we must also consider whether the child has an impairment(s) that medically equals a listing (see § 416.926 of this chapter). If the child's impairment(s) does not meet or medically equal a listing, we will determine whether the child's impairment(s) functionally equals the listings (see § 416.926a of this chapter) considering the factors in § 416.924a of this chapter. We use the rules in section § 416.994a of this chapter when we decide whether a child continues to be disabled.

100.01 *Category of Impairments, Low Birth Weight and Failure To Thrive.*

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100.04 *Low birth weight in infants from birth to attainment of age 1.*

A. Birth weight (see 100.00B) of less than 1200 grams.

OR

B. The following gestational age and birth weight:

Gestational age (in weeks)	Birth weight
37–40	2000 grams or less.
36	1875 grams or less.
35	1700 grams or less.
34	1500 grams or less.
33	1325 grams or less.

100.05 *Failure to thrive in children from birth to attainment of age 3 (see 100.00C), documented by A and B, or A and C.*

A. Growth failure as required in 1 or 2:

1. *For children from birth to attainment of age 2,* three weight-for-length measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate weight-for-length table in listing 105.08B1; or

2. *For children age 2 to attainment of age 3,* three body mass index (BMI)-for-age measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate BMI-for-age table in listing 105.08B2.

AND

B. Developmental delay (see 100.00C1 and C3), established by an acceptable medical source and documented by findings from one report of a standardized developmental assessment (see 100.00C3b) that:

1. Shows development not more than two-thirds of the level typically expected for the child's age; or

2. Results in a valid score that is at least two standard deviations below the mean.

OR

C. Developmental delay (see 100.00C3), established by an acceptable medical source and documented by findings from two narrative developmental reports (see 100.00C3c) that:

1. Are dated at least 120 days apart (see 100.00C1); and

2. Indicate development not more than two-thirds of the level typically expected for the child's age.

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103.00 RESPIRATORY SYSTEM

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F. *How do we evaluate growth failure due to any chronic respiratory disorder?*

1. To evaluate growth failure due to any chronic respiratory disorder, we require documentation of the oxygen supplementation described in 103.06A and the growth measurements in 103.06B within the same consecutive 12-month period. The dates of oxygen supplementation may be different from the dates of growth measurements.

2. Under 103.06B, we use the appropriate table(s) under 105.08B in the digestive system to determine whether a child's growth is less than the third percentile.

a. For children from birth to attainment of age 2, we use the weight-for-length table corresponding to the child's gender (Table I or Table II).

b. For children age 2 to attainment of age 18, we use the body mass index (BMI)-for-age table corresponding to the child's gender (Table III or Table IV).

c. BMI is the ratio of a child's weight to the square of his or her height. We calculate BMI using the formulas in 105.00G2c.

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103.06 *Growth failure due to any chronic respiratory disorder (see 103.00F), documented by:*

A. Hypoxemia with the need for at least 1.0 L/min of oxygen supplementation for at least 4 hours per day and for at least 90 consecutive days.

AND

B. Growth failure as required in 1 or 2:

1. *For children from birth to attainment of age 2,* three weight-for-length measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate weight-for-length table under 105.08B1; or

2. *For children age 2 to attainment of age 18,* three body mass index (BMI)-for-age measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate BMI-for-age table under 105.08B2.

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104.00 CARDIOVASCULAR SYSTEM

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C. *Evaluating Chronic Heart Failure.*

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2. *What evidence of CHF do we need?*

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b. To establish that you have *chronic* heart failure, we require that your medical history and physical examination describe characteristic symptoms and signs of pulmonary or systemic congestion or of limited cardiac output associated with abnormal findings on appropriate medically acceptable imaging. When a remediable factor, such as arrhythmia, triggers an acute episode of heart failure, you may experience restored cardiac function, and a chronic impairment may not be present.

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(ii) During infancy, other manifestations of chronic heart failure may include repeated lower respiratory tract infections.

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3. *How do we evaluate growth failure due to CHF?*

a. To evaluate growth failure due to CHF, we require documentation of the clinical findings of CHF described in 104.00C2 and the growth measurements in 104.02C within the same consecutive 12-month period. The dates of clinical findings may be different from the dates of growth measurements.

b. Under 104.02C, we use the appropriate table(s) under 105.08B in the digestive system to determine whether a child's growth is less than the third percentile.

(i) For children from birth to attainment of age 2, we use the weight-for-length table corresponding to the child's gender (Table I or Table II).

(ii) For children age 2 to attainment of age 18, we use the body mass index (BMI)-for-age table corresponding to the child's gender (Table III or Table IV).

(iii) BMI is the ratio of a child's weight to the square of his or her height. We calculate BMI using the formulas in 105.00G2c.

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104.02 *Chronic heart failure* while on a regimen of prescribed treatment, with symptoms and signs described in 104.00C2 and with one of the following:

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C. Growth failure as required in 1 or 2:

1. *For children from birth to attainment of age 2,* three weight-for-length measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate weight-for-length table under 105.08B1; or

2. *For children age 2 to attainment of age 18,* three body mass index (BMI)-for-age measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate BMI-for-age table under 105.08B2.

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105.00 DIGESTIVE SYSTEM

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G. *How do we evaluate growth failure due to any digestive disorder?*

1. To evaluate growth failure due to any digestive disorder, we require documentation of the laboratory findings of chronic nutritional deficiency described in 105.08A and the growth measurements in 105.08B within the same consecutive 12-month period. The dates of laboratory findings may be different from the dates of growth measurements.

2. Under 105.08B, we evaluate a child's growth failure by using the appropriate table for age and gender.

a. For children from birth to attainment of age 2, we use the weight-for-length table (see Table I or Table II).

b. For children age 2 to attainment of age 18, we use the body mass index (BMI)-for-age table (see Tables III or IV).

c. BMI is the ratio of a child's weight to the square of the child's height. We calculate BMI using one of the following formulas:

English Formula

BMI = [Weight in Pounds/(Height in Inches × Height in Inches)] × 703

Metric Formulas

BMI = Weight in Kilograms/(Height in Meters × Height in Meters)

BMI = [Weight in Kilograms/(Height in Centimeters × Height in Centimeters)] × 10,000

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105.08 *Growth failure due to any digestive disorder* (see 105.00G), documented by A and B:

A. Chronic nutritional deficiency present on at least two evaluations at least 60 days apart within a consecutive 12-month period documented by one of the following:

1. Anemia with hemoglobin less than 10.0 g/dL; or

2. Serum albumin of 3.0 g/dL or less;

AND

B. Growth failure as required in 1 or 2:

1. *For children from birth to attainment of age 2,* three weight-for-length measurements that are:

a. Within a 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on Table I or Table II; or

TABLE I—MALES BIRTH TO ATTAINMENT OF AGE 2 THIRD PERCENTILE VALUES FOR WEIGHT-FOR-LENGTH

Length (centimeters)	Weight (kilograms)	Length (centimeters)	Weight (kilograms)	Length (centimeters)	Weight (kilograms)
45.0	1.597	64.5	6.132	84.5	10.301
45.5	1.703	65.5	6.359	85.5	10.499
46.5	1.919	66.5	6.584	86.5	10.696
47.5	2.139	67.5	6.807	87.5	10.895
48.5	2.364	68.5	7.027	88.5	11.095
49.5	2.592	69.5	7.245	89.5	11.296
50.5	2.824	70.5	7.461	90.5	11.498
51.5	3.058	71.5	7.674	91.5	11.703
52.5	3.294	72.5	7.885	92.5	11.910
53.5	3.532	73.5	8.094	93.5	12.119
54.5	3.771	74.5	8.301	94.5	12.331
55.5	4.010	75.5	8.507	95.5	12.546
56.5	4.250	76.5	8.710	96.5	12.764
57.5	4.489	77.5	8.913	97.5	12.987
58.5	4.728	78.5	9.113	98.5	13.213
59.5	4.966	79.5	9.313	99.5	13.443
60.5	5.203	80.5	9.512	100.5	13.678
61.5	5.438	81.5	9.710	101.5	13.918
62.5	5.671	82.5	9.907	102.5	14.163
63.5	5.903	83.5	10.104	103.5	14.413

TABLE II—FEMALES BIRTH TO ATTAINMENT OF AGE 2 THIRD PERCENTILE VALUES FOR WEIGHT-FOR-LENGTH

Length (centimeters)	Weight (kilograms)	Length (centimeters)	Weight (kilograms)	Length (centimeters)	Weight (kilograms)
45.0	1.613	64.5	5.985	84.5	10.071
45.5	1.724	65.5	6.200	85.5	10.270
46.5	1.946	66.5	6.413	86.5	10.469
47.5	2.171	67.5	6.625	87.5	10.670
48.5	2.397	68.5	6.836	88.5	10.871
49.5	2.624	69.5	7.046	89.5	11.074
50.5	2.852	70.5	7.254	90.5	11.278
51.5	3.081	71.5	7.461	91.5	11.484
52.5	3.310	72.5	7.667	92.5	11.691
53.5	3.538	73.5	7.871	93.5	11.901
54.5	3.767	74.5	8.075	94.5	12.112
55.5	3.994	75.5	8.277	95.5	12.326
56.5	4.220	76.5	8.479	96.5	12.541
57.5	4.445	77.5	8.679	97.5	12.760
58.5	4.892	78.5	8.879	98.5	12.981
59.5	5.113	79.5	9.078	99.5	13.205
60.5	5.333	80.5	9.277	100.5	13.431
61.5	5.552	81.5	9.476	101.5	13.661
62.5	5.769	82.5	9.674	102.5	13.895
63.5	5.769	83.5	9.872	103.5	14.132

2. *For children age 2 to attainment of age 18,* three body mass index (BMI)-for-age measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on Table III or Table IV.

TABLE III—MALES AGE 2 TO ATTAINMENT OF AGE 18 THIRD PERCENTILE VALUES FOR BMI-FOR-AGE

Age (yrs. and mos.)	BMI	Age (yrs. and mos.)	BMI	Age (yrs. and mos.)	BMI
2.0 to 2.1	14.5	10.11 to 11.2	14.3	14.9 to 14.10	16.1
2.2 to 2.4	14.4	11.3 to 11.5	14.4	14.11 to 15.0	16.2
2.5 to 2.7	14.3	11.6 to 11.8	14.5	15.1 to 15.3	16.3
2.8 to 2.11	14.2	11.9 to 11.11	14.6	15.4 to 15.5	16.4
3.0 to 3.2	14.1	12.0 to 12.1	14.7	15.6 to 15.7	16.5
3.3 to 3.6	14.0	12.2 to 12.4	14.8	15.8 to 15.9	16.6
3.7 to 3.11	13.9	12.5 to 12.7	14.9	15.10 to 15.11	16.7
4.0 to 4.5	13.8	12.8 to 12.9	15.0	16.0 to 16.1	16.8
4.6 to 5.0	13.7	12.10 to 13.0	15.1	16.2 to 16.3	16.9
5.1 to 6.0	13.6	13.1 to 13.2	15.2	16.4 to 16.5	17.0
6.1 to 7.6	13.5	13.3 to 13.4	15.3	16.6 to 16.8	17.1
7.7 to 8.6	13.6	13.5 to 13.7	15.4	16.9 to 16.10	17.2
8.7 to 9.1	13.7	13.8 to 13.9	15.5	16.11 to 17.0	17.3
9.2 to 9.6	13.8	13.10 to 13.11	15.6	17.1 to 17.2	17.4
9.7 to 9.11	13.9	14.0 to 14.1	15.7	17.3 to 17.5	17.5
10.0 to 10.3	14.0	14.2 to 14.4	15.8	17.6 to 17.7	17.6
10.4 to 10.7	14.1	14.5 to 14.6	15.9	17.8 to 17.9	17.7
10.8 to 10.10	14.2	14.7 to 14.8	16.0	17.10 to 17.11	17.8

TABLE IV—FEMALES AGE 2 TO ATTAINMENT OF AGE 18 THIRD PERCENTILE VALUES FOR BMI-FOR-AGE

Age (yrs. and mos.)	BMI	Age (yrs. and mos.)	BMI	Age (yrs. and mos.)	BMI
2.0 to 2.2	14.1	10.8 to 10.10	14.0	14.3 to 14.5	15.6
2.3 to 2.6	14.0	10.11 to 11.2	14.1	14.6 to 14.7	15.7
2.7 to 2.10	13.9	11.3 to 11.5	14.2	14.8 to 14.9	15.8
2.11 to 3.2	13.8	11.6 to 11.7	14.3	14.10 to 15.0	15.9
3.3 to 3.6	13.7	11.8 to 11.10	14.4	15.1 to 15.2	16.0
3.7 to 3.11	13.6	11.11 to 12.1	14.5	15.3 to 15.5	16.1
4.0 to 4.4	13.5	12.2 to 12.4	14.6	15.6 to 15.7	16.2
4.5 to 4.11	13.4	12.5 to 12.6	14.7	15.8 to 15.10	16.3
5.0 to 5.9	13.3	12.7 to 12.9	14.8	15.11 to 16.0	16.4
5.10 to 7.6	13.2	12.10 to 12.11	14.9	16.1 to 16.3	16.5
7.7 to 8.4	13.3	13.0 to 13.2	15.0	16.4 to 16.6	16.6
8.5 to 8.10	13.4	13.3 to 13.4	15.1	16.7 to 16.9	16.7
8.11 to 9.3	13.5	13.5 to 13.7	15.2	16.10 to 17.0	16.8
9.4 to 9.8	13.6	13.8 to 13.9	15.3	17.1 to 17.3	16.9
9.9 to 10.0	13.7	13.10 to 14.0	15.4	17.4 to 17.7	17.0
10.1 to 10.4	13.8	14.1 to 14.2	15.5	17.8 to 17.11	17.1
10.5 to 10.7	13.9				

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106.00 GENITOURINARY IMPAIRMENTS

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E. *What other things do we consider when we evaluate your genitourinary impairment under specific listings?*

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5. *Growth failure due to any chronic renal disease (106.08).*

a. To evaluate growth failure due to any chronic renal disease, we require documentation of the laboratory findings described in 106.08A and the growth measurements in 106.08B within the same consecutive 12-month period. The dates of laboratory findings may be different from the dates of growth measurements.

b. Under 106.08B, we use the appropriate table(s) under 105.08B in the digestive system to determine whether a child's growth is less than the third percentile.

(i) For children from birth to attainment of age 2, we use the weight-for-length table corresponding to the child's gender (Table I or Table II).

(ii) For children age 2 to attainment of age 18, we use the body mass index (BMI)-for-age table corresponding to the child's gender (Table III or Table IV).

(iii) BMI is the ratio of a child's weight to the square of his or her height. We calculate BMI using the formulas in 105.00G2c.

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106.08 *Growth failure due to any chronic renal disease* (see 106.00E5), with:

A. Serum creatinine of 2 mg/dL or greater, documented at least two times within a consecutive 12-month period with at least 60 days between measurements.

AND

B. Growth failure as required in 1 or 2:

1. *For children from birth to attainment of age 2,* three weight-for-length measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate weight-for-length table under 105.08B1; or

2. *For children age 2 to attainment of age 18,* three body mass index (BMI)-for-age measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate BMI-for-age table under 105.08B2.

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114.00 IMMUNE SYSTEM DISORDERS

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F. *How do we document and evaluate human immunodeficiency virus (HIV) infection?* * * *

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4. *HIV infection manifestations specific to children.*

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d. *Growth failure due to HIV immune suppression.*

(i) To evaluate growth failure due to HIV immune suppression, we require documentation of the laboratory values described in 114.08H1 and the growth measurements in 114.08H2 or 114.08H3 within the same consecutive 12-month period. The dates of laboratory findings may be different from the dates of growth measurements.

(ii) Under 114.08H2 and 114.08H3, we use the appropriate table under 105.08B in the digestive system to determine whether a child's growth is less than the third percentile.

A. For children from birth to attainment of age 2, we use the weight-for-length table corresponding to the child's gender (Table I or Table II).

B. For children age 2 to attainment of age 18, we use the body mass index (BMI)-for-age table corresponding to the child's gender (Table III or Table IV).

C. BMI is the ratio of a child's weight to the square of his or her height. We calculate BMI using the formulas in 105.00G2c.

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114.08 *Human immunodeficiency virus (HIV) infection.* * * *

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H. *Immune suppression and growth failure* (see 114.00F4d) documented by 1 and 2, or by 1 and 3.

1. CD4 measurement:

a. *For children from birth to attainment of age 5,* CD4 percentage of less than 20 percent; or

b. *For children age 5 to attainment of age 18,* absolute CD4 count of less than 200 cells/mm^3, or CD4 percentage of less than 14 percent; and

2. *For children from birth to attainment of age 2,* three weight-for-length measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate weight-for-length table under 105.08B1; or

3. *For children age 2 to attainment of age 18,* three body mass index (BMI)-for-age measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate BMI-for-age table under 105.08B2.

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

Subpart I — [Amended]

■ 3. 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 1383b); 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).

■ 4. Amend § 416.924b by revising paragraph (b) to read as follows:

§ 416.924b Age as a factor of evaluation in the sequential evaluation process for children.

* * * * *

(b) *Correcting chronological age of premature infants.* We generally use chronological age (a child's age based on birth date) when we decide whether, or the extent to which, a physical or mental impairment or combination of impairments causes functional limitations. However, if you were born prematurely, we may consider you younger than your chronological age when we evaluate your development. We may use a ''corrected'' chronological age (CCA); that is, your chronological age adjusted by a period of gestational prematurity. We consider an infant born at less than 37 weeks' gestation to be born prematurely.

(1) We compute your CCA by subtracting the number of weeks of prematurity (the difference between 40 weeks of full-term gestation and the number of actual weeks of gestation) from your chronological age. For example, if your chronological age is 20 weeks but you were born at 32 weeks gestation (8 weeks premature), then your CCA is 12 weeks.

(2) We evaluate developmental delay in a premature child until the child's prematurity is no longer a relevant factor, generally no later than about chronological age 2.

(i) If you have not attained age 1 and were born prematurely, we will assess your development using your CCA.

(ii) If you are over age 1 and have a developmental delay, and prematurity is still a relevant factor, we will decide whether to correct your chronological age. We will base our decision on our judgment and all the facts in your case. If we decide to correct your chronological age, we may correct it by subtracting the full number of weeks of prematurity or a lesser number of weeks. If your developmental delay is the result of your medically determinable impairment(s) and is not attributable to your prematurity, we will decide not to correct your chronological age.

(3) Notwithstanding the provisions in paragraph (b)(1) of this section, we will not compute a CCA if the medical evidence shows that your treating source or other medical source has already taken your prematurity into consideration in his or her assessment of your development. We will not compute a CCA when we find you disabled under listing 100.04 of the Listing of Impairments.

§ 416.926a [Amended]

■ 5. Amend § 416.926a by removing paragraphs (m)(6) and (m)(7) and redesignating paragraph (m)(8) as (m)(6).

■ 6. Amend § 416.934 by adding paragraphs (j) and (k) to read as follows:

§ 416.934 Impairments which may warrant a finding of presumptive disability or presumptive blindness.

* * * * *

(j) Infants weighing less than 1200 grams at birth, until attainment of 1 year of age.

(k) Infants weighing at least 1200 but less than 2000 grams at birth, and who are small for gestational age, until attainment of 1 year of age. (Small for gestational age means a birth weight that is at or more than 2 standard deviations below the mean or that is less than the 3rd growth percentile for the gestational age of the infant.)

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DEPARTMENT OF TRANSPORTATION

Pipeline and Hazardous Materials Safety Administration

49 CFR Part 109

[Docket No. PHMSA–2012–0259 (HM–258B)]

RIN 2137–AE98

Hazardous Materials: Enhanced Enforcement Procedures—Resumption of Transportation

AGENCY: Pipeline and Hazardous Materials Safety Administration (PHMSA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: PHMSA is proposing to address certain matters identified in the Hazardous Materials Transportation Safety Act of 2012 related to the Department's enhanced inspection, investigation, and enforcement authority. Specifically, we are proposing to amend the opening of packages provision to include requirements for perishable hazardous material; add a new notification section; and add a new equipment section to the Department's procedural regulations. For the mandates to address certain matters related to the Department's enhanced inspection, investigation, and enforcement authority, we are proposing no additional regulatory changes. We believe that the Department's current