

POLICY INTERPRETATION RULING

TITLES II AND XVI: EVALUATION OF OBESITY

This Ruling supersedes SSR 00-3p, Titles II and XVI: Evaluation of Obesity (65 FR 31039, May 15, 2000).

PURPOSE: To provide guidance on SSA policy concerning the evaluation of obesity in disability claims filed under titles II and XVI of the Social Security Act (the Act).

CITATIONS: Sections 216(i), 223(d), 223(f), 1614(a), and 1614(c) of the Act, as amended; Regulations No. 4, subpart P, sections 404.1502, 404.1508, 404.1509, 404.1512, 404.1520, 404.1521, 404.1523, 404.1525, 404.1526, 404.1528, 404.1529, 404.1530, 404.1545, 404.1546, 404.1561, 404.1594, and appendix 1; and Regulations No. 16, subpart I, sections 416.902, 416.908, 416.909, 416.912, 416.920, 416.921, 416.923, 416.924, 416.925, 416.926, 416.926a, 416.928, 416.929, 416.930, 416.933, 416.945, 416.946, 416.961, 416.994, and 416.994a.

INTRODUCTION: On August 24, 1999, we¹ published a final rule in the Federal Register deleting listing 9.09, Obesity, from the Listing of Impairments in 20 CFR, subpart P, appendix 1 (the listings). The final rule was effective on October 25, 1999. 64 FR 46122 (1999).

We stated in the preamble to the final rule that we deleted listing 9.09 because our experience adjudicating cases under this listing indicated that the criteria in the listing were not appropriate indicators of listing-level severity. In our experience, the criteria in listing 9.09 did not represent a degree of functional limitation that would prevent an individual from engaging in any gainful activity.

However, even though we deleted listing 9.09, we made some changes to the listings to ensure that obesity is still addressed in our listings. In the final rule, we added paragraphs to the prefaces of the musculoskeletal, respiratory, and cardiovascular body system listings that provide guidance about the potential effects obesity has in causing or contributing to impairments in those body systems. See listings sections 1.00Q, 3.00I, and 4.00F. The paragraphs state that we consider obesity to be a medically determinable impairment and remind adjudicators to consider its effects when evaluating disability. The provisions also remind adjudicators that the combined effects of obesity with other impairments can be greater than the

¹ The terms we and us in this Social Security Ruling have the same meaning as in 20 CFR 404.1502 and 416.902. We or us refers to either the Social Security Administration or the State agency making the disability or blindness determination; i.e., our adjudicators at all levels of the administrative review process and our quality reviewers.

effects of each of the impairments considered separately. They also instruct adjudicators to consider the effects of obesity not only under the listings but also when assessing a claim at other steps of the sequential evaluation process, including when assessing an individual's residual functional capacity.

When we published that final rule, in response to public comments, we stated that we would provide additional guidance in a Social Security Ruling (SSR). (64 FR at 46126) On May 15, 2000, we published SSR 00-3p (65 FR 31039) to provide that additional guidance by discussing how we evaluate obesity in disability claims filed by adults and children under titles II and XVI of the Act. Since then, we have published several final rules that revise some of the criteria we use to evaluate disability claims under titles II and XVI of the Social Security Act. We are issuing this SSR to reflect the changes to the rules that we have published since we published SSR 00-3p.

POLICY INTERPRETATION:

General

1. What is obesity?

Obesity is a complex, chronic disease characterized by excessive accumulation of body fat. Obesity is generally the result of a combination of factors (e.g., genetic, environmental, and behavioral).

In one sense, the cause of obesity is simply that the energy (food) taken in exceeds the energy expended by the individual's body. However, the influences on intake, the influences on expenditure, the metabolic processes in between, and the overall genetic controls are complex and not well understood.

The National Institutes of Health (NIH) established medical criteria for the diagnosis of obesity in its Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults (NIH Publication No. 98-4083, September 1998). These guidelines classify overweight and obesity in adults according to Body Mass Index (BMI). BMI is the ratio of an individual's weight in kilograms to the square of his or her height in meters (kg/m^2). For adults, both men and women, the Clinical Guidelines describe a BMI of 25-29.9 as "overweight" and a BMI of 30.0 or above as "obesity."

The Clinical Guidelines recognize three levels of obesity. Level I includes BMIs of 30.0-34.9. Level II includes BMIs of 35.0-39.9. Level III, termed "extreme" obesity and representing the greatest risk for developing obesity-related impairments, includes BMIs greater than or equal to 40. These levels describe the extent of obesity, but they do not correlate with any specific degree of functional loss.

In addition, although there is often a significant correlation between BMI and excess body fat, this is not always the case. The Clinical Guidelines also provide for considering whether an individual of a given height and weight has excess body fat when determining whether he or she has obesity. Thus, it is possible for someone whose BMI is below 30 to have obesity if too large a percentage of the weight is from fat. Likewise, someone with a BMI above 30 may not have obesity if a large percentage of the weight is from muscle. However, in most cases, the BMI will show whether the individual has obesity. It also will usually be evident from the information in the case record whether the individual should not be found to have obesity, despite a BMI of 30.0 or above. See question 4, below.

The Clinical Guidelines do not provide criteria for diagnosing obesity in children. However, a

BMI greater than or equal to the 95th percentile for a child's age is generally considered sufficient to establish the diagnosis of obesity. (BMIs in the 95th percentile vary by age and sex of the child.) BMI-for-age-and-gender charts are published in medical textbooks or professional journals and by the National Center for Health Statistics. As with adults, the amount of body fat is considered in making the diagnosis of obesity in children.

Treatment for obesity is often unsuccessful. Even if treatment results in weight loss at first, weight lost is often regained, despite the efforts of the individual to maintain the loss. See question 13, below, for additional discussion of obesity treatment.

2. How does obesity affect physical and mental health?

Obesity is a risk factor that increases an individual's chances of developing impairments in most body systems. It commonly leads to, and often complicates, chronic diseases of the cardiovascular, respiratory, and musculoskeletal body systems. Obesity increases the risk of developing impairments such as type II (so-called adult onset) diabetes mellitus—even in children; gall bladder disease; hypertension; heart disease; peripheral vascular disease; dyslipidemia (abnormal levels of fatty substances in the blood); stroke; osteoarthritis; and sleep apnea. It is associated with endometrial, breast, prostate, and colon cancers, and other physical impairments. Obesity may also cause or contribute to mental impairments such as depression. The effects of obesity may be subtle, such as the loss of mental clarity and slowed reactions that may result from obesity-related sleep apnea.

The fact that obesity is a risk factor for other impairments does not mean that individuals with obesity necessarily have any of these impairments. It means that they are at greater than average risk for developing the other impairments.

3. How do we consider obesity in the sequential evaluation process?²

We will consider obesity in determining whether:

- The individual has a medically determinable impairment. See question 4.
- The individual's impairment(s) is severe. See question 6.
- The individual's impairment(s) meets or equals the requirements of a listed impairment in the listings. See question 7. (We use special rules for some continuing disability reviews. See question 11.)
- The individual's impairment(s) prevents him or her from doing past relevant work and other work that exists in significant numbers in the national economy. However, these steps apply only in title II and adult title XVI cases. See questions 8 and 9.

² For ease of reading, we refer in this Ruling only to the steps of the sequential evaluation processes for initial adult and childhood claims. 20 CFR 404.1520, 416.920, and 416.924. We use separate sequential evaluation processes when we do continuing disability reviews; i.e., reviews to determine whether individuals who are receiving disability benefits are still disabled or when we determine whether an individual has a "closed period of disability." These rules are set out in 20 CFR 404.1594, 416.994, and 416.994a, and the guidance in this Ruling applies to all of the appropriate steps in those regulations as well. However, in some continuing disability review cases, we will still consider the provisions of former listings 9.09 and 10.10. See question 11.

4. How is obesity identified as a medically determinable impairment?

When establishing the existence of obesity, we will generally rely on the judgment of a physician who has examined the claimant and reported his or her appearance and build, as well as weight and height. Thus, in the absence of evidence to the contrary in the case record, we will accept a diagnosis of obesity given by a treating source or by a consultative examiner. However, if there is evidence that indicates that the diagnosis is questionable and the evidence is inadequate to determine whether or not the individual is disabled, we will contact the source for clarification, using the guidelines in 20 CFR 404.1512(e) and 416.912(e).

When the evidence in a case does not include a diagnosis of obesity, but does include clinical notes or other medical records showing consistently high body weight or BMI, we may ask a medical source to clarify whether the individual has obesity. However, in most such cases we will use our judgment to establish the presence of obesity based on the medical findings and other evidence in the case record, even if a treating or examining source has not indicated a diagnosis of obesity. Generally, we will not purchase a consultative examination just to establish the diagnosis of obesity.

When deciding whether an individual has obesity, we will also consider the individual's weight over time.³ We will not count minor, short-term weight loss. We will consider the individual to have obesity as long as his or her weight or BMI shows essentially a consistent pattern of obesity. (See question 13 for a discussion of weight loss and medical improvement.)

Finally, there are a number of methods for measuring body fat and, if such information is in a case record, we will consider it. However, we will not purchase such testing. In most cases, the medical and other evidence in the case record will establish whether the individual has obesity.

5. Can we find an individual disabled based on obesity alone?

If an individual has the medically determinable impairment obesity that is "severe" as described in question 6, we may find that the obesity medically equals a listing. (In the case of a child seeking benefits under title XVI, we may also find that it functionally equals the listings.) We may also find in a title II claim, or an adult claim under title XVI, that the obesity results in a finding that the individual is disabled based on his or her residual functional capacity (RFC), age,

³ As with all impairments, to establish a finding of disability based on obesity, in whole or in part, the statutory duration requirement must be satisfied. See 20 CFR 404.1509 or 416.909, and SSR 82-52, "Titles II and XVI: Duration of the Impairment" (superseded in part by SSR 91-7c).

education, and past work experience. However, we will also consider the possibility of coexisting or related conditions, especially as the level of obesity increases. We provide an example of when we may find obesity to medically equal a listing in question 7.

Sequential Evaluation:
Step 2, Severe Impairment

6. When is obesity a “severe” impairment?

As with any other medical condition, we will find that obesity is a "severe" impairment when, alone or in combination with another medically determinable physical or mental impairment(s), it significantly limits an individual's physical or mental ability to do basic work activities. (For children applying for disability under title XVI, we will find that obesity is a "severe" impairment when it causes more than minimal functional limitations.) We will also consider the effects of any symptoms (such as pain or fatigue) that could limit functioning. (See SSR 85-28, "Titles II and XVI: Medical Impairments That Are Not Severe" and SSR 96-3p, "Titles II and XVI: Considering Allegations of Pain and Other Symptoms In Determining Whether a Medically Determinable Impairment Is Severe.") Therefore, we will find that an impairment(s) is "not severe" only if it is a slight abnormality (or a combination of slight abnormalities) that has no more than a minimal effect on the individual's ability to do basic work activities (or, for a child applying under title XVI, if it causes no more than minimal functional limitations).

There is no specific level of weight or BMI that equates with a "severe" or a "not severe" impairment. Neither do descriptive terms for levels of obesity (e.g., “severe,” “extreme,” or “morbid” obesity) establish whether obesity is or is not a "severe" impairment for disability program purposes. Rather, we will do an individualized assessment of the impact of obesity on an individual's functioning when deciding whether the impairment is severe.

Sequential Evaluation
Step 3, The Listings

7. How do we evaluate obesity at step 3 of sequential evaluation, the listings?

Obesity may be a factor in both "meets" and "equals" determinations.

Because there is no listing for obesity, we will find that an individual with obesity "meets" the requirements of a listing if he or she has another impairment that, by itself, meets the requirements of a listing. We will also find that a listing is met if there is an impairment that, in combination with obesity, meets the requirements of a listing. For example, obesity may increase the severity of coexisting or related impairments to the extent that the combination of impairments meets the requirements of a listing. This is especially true of musculoskeletal, respiratory, and cardiovascular impairments. It may also be true for other coexisting or related impairments, including mental disorders.

For example, when evaluating impairments under mental disorder listings 12.05C, 112.05D, or 112.05F, obesity that is "severe," as explained in question 6, satisfies the criteria in listing 12.05C for a physical impairment imposing an additional and significant work-related limitation of function and in listings 112.05D and 112.05F for a physical impairment imposing an additional and significant limitation of function. We will find the requirements of listing 12.05 are met if an individual's impairment satisfies the diagnostic description in the introductory paragraph of listing 12.05 and any one of the four sets of criteria in the listing. In the case of an individual under age 18, we will find that the requirements of listing 112.05 are met if the child's impairment satisfies the diagnostic description in the introductory paragraph of listing 112.05 and any one of the six sets of criteria in the listing. (See sections 12.00A and 112.00A of the listings.)

We may also find that obesity, by itself, is medically equivalent to a listed impairment (or, in the case of a child applying under title XVI, also functionally equivalent to the listings). For example, if the obesity is of such a level that it results in an inability to ambulate effectively, as defined in sections 1.00B2b or 101.00B2b of the listings, it may substitute for the major dysfunction of a joint(s) due to any cause (and its associated criteria), with the involvement of one major peripheral weight-bearing joint in listings 1.02A or 101.02A, and we will then make a finding of medical equivalence. (See question 8 for further discussion of evaluating the functional effects of obesity, including functional equivalence determinations for children applying for benefits under title XVI.)

We will also find equivalence if an individual has multiple impairments, including obesity, no one of which meets or equals the requirements of a listing, but the combination of impairments is equivalent in severity to a listed impairment. For example, obesity affects the cardiovascular

and respiratory systems because of the increased workload the additional body mass places on these systems. Obesity makes it harder for the chest and lungs to expand. This means that the respiratory system must work harder to provide needed oxygen. This in turn makes the heart work harder to pump blood to carry oxygen to the body. Because the body is working harder at rest, its ability to perform additional work is less than would otherwise be expected. Thus, we may find that the combination of a pulmonary or cardiovascular impairment and obesity has signs, symptoms, and laboratory findings that are of equal medical

significance to one of the respiratory or cardiovascular listings.⁴

However, we will not make assumptions about the severity or functional effects of obesity combined with other impairments. Obesity in combination with another impairment may or may not increase the severity or functional limitations of the other impairment. We will evaluate each case based on the information in the case record.

Sequential Evaluation:
Steps 4 and 5, Assessing Functioning in Adults
Step 3, Assessing Functional Equivalence in Children

8. How do we evaluate obesity in assessing residual functional capacity in adults and functional equivalence in children?

Obesity can cause limitation of function. The functions likely to be limited depend on many factors, including where the excess weight is carried. An individual may have limitations in any of the exertional functions such as sitting, standing, walking, lifting, carrying, pushing, and pulling. It may also affect ability to do postural functions, such as climbing, balance, stooping, and crouching. The ability to manipulate may be affected by the presence of adipose (fatty) tissue in the hands and fingers. The ability to tolerate extreme heat, humidity, or hazards may also be affected.

The effects of obesity may not be obvious. For example, some people with obesity also have sleep apnea. This can lead to drowsiness and lack of mental clarity during the day. Obesity may also affect an individual's social functioning.

An assessment should also be made of the effect obesity has upon the individual's ability to perform routine movement and necessary physical activity within the work environment. Individuals with obesity may have problems with the ability to sustain a function over time. As explained in SSR 96-8p ("Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims"), our RFC assessments must consider an individual's maximum remaining ability to do sustained work activities in an ordinary work setting on a regular and continuing basis. A "regular and continuing basis" means 8 hours a day, for 5 days a week, or an equivalent work schedule.⁵ In cases involving obesity, fatigue may affect the individual's physical and mental ability to sustain work activity. This may be particularly true in cases involving sleep apnea.

⁴ For our regulations and rulings on the consideration of medical or psychological consultant opinions in determining medical equivalence, see 20 CFR 404.1526(c) and 416.926(c), and SSR 96-6p, "Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence."

⁵ However, see footnote 2 of SSR 96-8p. That footnote explains that the ability to work 8 hours a day for 5 days a week is not always required for a finding at step 4 of the sequential evaluation process for adults when an individual can do

The combined effects of obesity with other impairments may be greater than might be expected without obesity. For example, someone with obesity and arthritis affecting a weight-bearing joint may have more pain and limitation than might be expected from the arthritis alone.

For a child applying for benefits under title XVI, we may evaluate the functional consequences of obesity (either alone or in combination with other impairments) to decide if the child's impairment(s) functionally equals the listings. For example, the functional limitations imposed by obesity, by itself or in combination with another impairment(s), may establish an extreme limitation in one domain of functioning (e.g., Moving about and manipulating objects) or marked limitations in two domains (e.g., Moving about and manipulating objects and Caring for yourself).

As with any other impairment, we will explain how we reached our conclusions on whether obesity caused any physical or mental limitations.

9. How can we consider obesity in the assessment of RFC when SSR 96-8p says, "Age and body habitus are not factors in assessing RFC"?

The SSR goes on to say that "[i]t is incorrect to find that an individual has limitations beyond those caused by his or her medically determinable impairment(s) and any related symptoms, due to such factors as age and natural body build, and the activities the individual was accustomed to doing in his or her previous work." (Emphasis added.) We included the italicized statement in the SSR to distinguish between individuals who have a medically determinable impairment of obesity and individuals who do not. When we identify obesity as a medically determinable impairment (see question 4, above), we will consider any functional limitations resulting from the obesity in the RFC assessment, in addition to any limitations resulting from any other physical or mental impairments that we identify.

past relevant work that was part-time work, if that work was substantial gainful activity, performed within the applicable period, and lasted long enough for the person to learn to do it.

Effect of the Rules Change:

**Claims in Which Prior Listings Apply
and Do Not Apply**

10. How does the deletion of listing 9.09 affect claims pending on October 25, 1999?

The final rules that deleted the listing became effective on October 25, 1999. The final rules deleting listing 9.09 apply to claims that were filed before October 25, 1999, and that were awaiting an initial determination or that were pending appeal at any level of the administrative review process or that had been appealed to court. The change affected the entire claim, including the period before October 25, 1999. This is our usual policy with respect to any change in our listings.

However, different rules apply to individuals who were already found eligible to receive benefits prior to October 25, 1999. For an explanation of how we apply listing 9.09 in continuing disability reviews, see question 11.

11. How does deletion of listing 9.09 affect claims already allowed?

Deletion of listing 9.09 does not affect the entitlement or eligibility of individuals receiving benefits because their impairment(s) met or equaled that listing. We will not find that their disabilities have ended just because we deleted listing 9.09.

We must periodically review all claims to determine whether the individual's disability continues.

When we conduct a periodic continuing disability review (CDR), we will not find that an individual's disability has ended based on a change in a listing. For individuals receiving disability benefits under title II and adults receiving payments under title XVI, we apply the medical improvement review standard described in 20 CFR 404.1594 and 416.994.

We will first evaluate whether the individual's impairment(s) has medically improved and, if so, whether any medical improvement is related to the ability to work. If the individual's impairment(s) has not medically improved, we will find that he or she is still disabled, unless we find that an exception to the medical improvement standard applies. Even if the impairment(s) has medically improved, we will find that the improvement is not related to the ability to work if the impairment(s) continues to meet or equal the same listing section used to make our most recent favorable decision. This is true even if we have since deleted the listing section that we used to make the most recent favorable decision. See 20 CFR 404.1594(c)(3)(i) and 416.994(b)(2)(iv)(A). We apply a similar provision when we do CDRs for individuals who have not attained age 18 and who are eligible for title XVI benefits based on disability (20 CFR 416.994a(b)(2)).

Even if the individual's impairment(s) has medically improved and no longer meets or equals prior listing 9.09, we must still determine whether he or she is currently disabled, considering all of the impairments.

12. What amount of weight loss would represent "medical improvement"?

Because an individual's weight may fluctuate over time and minor weight changes are of little significance to an individual's ability to function, it is not appropriate to conclude that an individual with obesity has medically improved because of a minor weight loss. A loss of less than 10 percent of initial body weight is too minor to result in a finding that there has been medical improvement in the obesity. However, we will consider that obesity has medically improved if an individual maintains a consistent loss of at least 10 percent of body weight for at least 12 months. We will not count minor, short-term changes in weight when we decide whether an individual has maintained the loss consistently.

If there is a coexisting or related condition(s) and the obesity has not improved, we will still consider whether the coexisting or related condition(s) has medically improved.

If we find that there has been medical improvement in obesity or in any coexisting or related condition(s), we must also decide whether the medical improvement is related to the ability to work. If necessary, we will also decide whether any exceptions to the medical improvement review standard apply and, if appropriate, whether the individual is currently disabled.

13. What are the goals and methods of treatment for obesity?

Obesity is a disease that requires treatment, although in most people the effect of treatment is limited. However, if untreated, it tends to progress.

A common misconception is that the goal of treatment is to reduce weight to a "normal" level. Actually, the goal of realistic medical treatment for obesity is only to reduce weight by a reasonable amount that will improve health and quality of life. People with extreme obesity, even with treatment, will generally continue to have obesity. Despite short-term progress, most treatments for obesity do not have a high success rate.

Recommended treatment for obesity depends upon the level of obesity. At levels I and II (BMI 30.0-39.9), treatment usually consists of behavior modification (diet and exercise) with the option of medication, usually either in the form of a fat-blocking drug or an appetite suppressant. Some people do not respond to medication, while others experience negative side effects. (In making our decision, we will also consider any side effects of medication the individual experiences.) Individuals with coexisting or related conditions may not be able to take medication because of its effects on their other conditions.

Generally, physicians recommend surgery when obesity has reached level III (BMI 40 or greater). However, surgery may also be an option at level II (BMI 35-39.9) if there is a serious coexisting or related condition. Obesity surgery modifies the stomach, the intestines, or both in order to reduce the amount of food that the individual can eat at one meal or the time food is available for digestion and absorption. Surgery is generally a last resort with individuals for whom other forms of treatment have failed. Some individuals also experience significant negative side effects from surgery (e.g., "dumping syndrome" – that is, rapid emptying of the stomach's contents marked by various signs and symptoms).

Obesity is a life-long disease. Even when treatment has been successful, individuals with obesity generally need to stay in treatment or they will gain weight again, just as individuals with other

impairments may need to stay in treatment. Individuals who have had surgery should receive continuing follow-up care because of health risks related to the surgery. As with other chronic disorders, effective treatment of obesity requires regular medical follow-up.

14. How do we evaluate failure to follow prescribed treatment in obesity cases?

Before failure to follow prescribed treatment for obesity can become an issue in a case, we must first find that the individual is disabled because of obesity or a combination of obesity and another impairment(s). Our regulations at 20 CFR 404.1530 and 416.930 provide that, in order to get benefits, an individual must follow treatment prescribed by his or her physician if the treatment can restore the ability to work, unless the individual has an acceptable reason for failing to follow the prescribed treatment. We will rarely use "failure to follow prescribed treatment" for obesity to deny or cease benefits.

SSR 82-59, "Titles II and XVI: Failure To Follow Prescribed Treatment," explains that we will find failure to follow prescribed treatment only when all of the following conditions exist:

- The individual has an impairment(s) that meets the definition of disability, including the duration requirement, and
- A treating source has prescribed treatment that is clearly expected to restore the ability to engage in substantial gainful activity, and
- The evidence shows that the individual has failed to follow prescribed treatment without a good reason.

If an individual who is disabled because of obesity (alone or in combination with another impairment(s)) does not have a treating source who has prescribed treatment for the obesity, there is no issue of failure to follow prescribed treatment.

The treatment must be prescribed by a treating source, as defined in our regulations at 20 CFR 404.1502 and 416.902, not simply recommended. A treating source's statement that an individual "should" lose weight or has "been advised" to get more exercise is not prescribed treatment.

When a treating source has prescribed treatment for obesity, the treatment must clearly be expected to improve the impairment to the extent that the person will not be disabled. As noted in question 13, the goals of treatment for obesity are generally modest, and treatment is often ineffective. Therefore, we will not find failure to follow prescribed treatment unless there is clear evidence that treatment would be successful. The obesity must be expected to improve to the point at which the individual would not meet our definition of disability, considering not only the obesity, but any other impairment(s).

Finally, even if we find that a treating source has prescribed treatment for obesity, that the treatment is clearly expected to restore the ability to engage in SGA, and that the individual is

not following the prescribed treatment, we must still consider whether the individual has a good reason for doing so. In making this finding, we will follow the guidance in our regulations and SSR 82-59, which provide that acceptable justifications for failing to follow prescribed treatment include, but are not limited to, the following:

- The specific medical treatment is contrary to the teaching and tenets of the individual's religion.
- The individual is unable to afford prescribed treatment that he or she is willing to accept, but for which free community resources are unavailable.
- The treatment carries a high degree of risk because of the enormity or unusual nature of the procedure.

In this regard, most health insurance plans and Medicare do not defray the expense of treatment for obesity. Thus, an individual who might benefit from behavioral or drug therapy might not be able to afford it. Also, because not enough is known about the long-term effects of medications used to treat obesity, some people may be reluctant to use them due to the potential risk.

Because of the risks and potential side effects of surgery for obesity, we will not find that an individual has failed to follow prescribed treatment for obesity when the prescribed treatment is surgery.

EFFECTIVE DATE: This Ruling is effective upon publication in the **Federal Register**.

CROSS-REFERENCES: SSR 82-52, "Titles II and XVI: Duration of the Impairment;" SSR 82-59, "Titles II and XVI: Failure To Follow Prescribed Treatment;" SSR 85-28, "Titles II and XVI: Medical Impairments That Are Not Severe;" SSR 96-3p, "Titles II and XVI: Considering Allegations of Pain and Other Symptoms In Determining Whether a Medically Determinable Impairment Is Severe;" SSR 96-6p, "Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence;" SSR 96-8p, "Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims;" and Program Operations Manual System sections DI 23010.005 ff., DI 24510.006, DI 24570.001, DI 34001.010, DI 34001.014, and DI 34001.016.