Disability Evaluation Under Social Security

*14.08 Human immunodeficiency virus (HIV) infection. With documentation as described in 14.00F and one of the following:

A. Bacterial infections:

1. Mycobacterial infection (for example, caused by M. avium - intracellulare, M. kansasii, or M. tuberculosis) at a site other than the lungs, skin, or cervical or hilar lymph nodes, or pulmonary tuberculosis resistant to treatment; or

2. Nocardiosis; or

3. Salmonella bacteremia, recurrent non-typhoid; or

4. Multiple or recurrent bacterial infections, including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment three or more times in a 12-month period.

OR

B. Fungal infections:

1. Aspergillosis; or

2. Candidiasis involving the esophagus, trachea, bronchi, or lungs, or at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or

3. Coccidioidomycosis, at a site other than the lungs or lymph nodes; or

4. Cryptococcosis, at a site other than the lungs (for example, cryptococcal meningitis); or

5. Histoplasmosis, at a site other than the lungs or lymph nodes; or

6. Mucormycosis; or

7. Pneumocystis pneumonia or extrapulmonary Pneumocystis infection.

OR

C. Protozoan or helminthic infections:

1. Cryptosporidiosis, isosporiasis, or microsporidiosis, with diarrhea lasting for 1 month or longer; or

2. Strongyloidiasis, extra-intestinal; or

3. Toxoplasmosis of an organ other than the liver, spleen, or lymph nodes.

OR

D. Viral infections:

1. Cytomegalovirus disease (documented as described in 14.00F3b(ii)) at a site other than the liver, spleen or lymph nodes; or

2. Herpes simplex virus causing:

a. Mucocutaneous infection (for example, oral, genital, perianal) lasting for 1 month or longer; or

b. Infection at a site other than the skin or mucous membranes (for example, bronchitis, pneumonitis, esophagitis, or encephalitis); or

c. Disseminated infection; or

3. Herpes zoster:

a. Disseminated; or

b. With multidermatomal eruptions that are resistant to treatment; or

4. Progressive multifocal leukoencephalopathy.

OR

E. Malignant neoplasms:

1. Carcinoma of the cervix, invasive, FIGO stage II and beyond; or

2. Kaposi's sarcoma with:

a. Extensive oral lesions; or

b. Involvement of the gastrointestinal tract, lungs, or other visceral organs; or

3. Lymphoma (for example, primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma, Hodgkin's disease); or

4. Squamous cell carcinoma of the anal canal or anal margin.

OR

F. Conditions of the skin or mucous membranes (other than described in B2, D2, or D3, above), with extensive fungating or ulcerating lesions not responding to treatment (for example, dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal C andida, condyloma caused by human Papillomavirus, genital ulcerative disease).

OR

G. HIV encephalopathy, characterized by cognitive or motor dysfunction that limits function and progresses.

OR

H. HIV wasting syndrome, characterized by involuntary weight loss of 10 percent or more of baseline (computed based on pounds, kilograms, or body mass index (BMI)) or other significant involuntary weight loss as described in 14.00F5, and in the absence of a concurrent illness that could explain the findings. With either:

1. Chronic diarrhea with two or more loose stools daily lasting for 1 month or longer; or

2. Chronic weakness and documented fever greater than 38 flC (100.4 flF) for the majority of 1 month or longer.

OR

I. Diarrhea, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding.

OR

J. One or more of the following infections (other than described in A-I, above). The infection(s) must either be resistant to treatment or require hospitalization or intravenous treatment three or more times in a 12-month period.

1. Sepsis; or

2. Meningitis; or

3. Pneumonia; or

4. Septic arthritis; or

5. Endocarditis; or

6. Sinusitis documented by appropriate medically acceptable imaging.

OR

K. Repeated (as defined in 14.00I3) manifestations of HIV infection, including those listed in 14.08A-J, but without the requisite findings for those listings (for example, carcinoma of the cervix not meeting the criteria in 14.08E, diarrhea not meeting the criteria in 14.08I), or other manifestations (for example, oral hairy leukoplakia, myositis, pancreatitis, hepatitis, peripheral neuropathy, glucose intolerance, muscle weakness, cognitive or other mental limitation) resulting in significant, documented symptoms or signs (for example, severe fatigue, fever, malaise, involuntary weight loss, pain, night sweats, nausea, vomiting, headaches, or insomnia) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.00F. How do we document and evaluate human immunodeficiency virus (HIV) infection?

Any individual with HIV infection, including one with a diagnosis of acquired immune deficiency syndrome (AIDS), may be found disabled under 14.08 if his or her impairment meets the criteria in that listing or is medically equivalent to the criteria in that listing.

1. Documentation of HIV infection. The medical evidence must include documentation of HIV infection. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice. When you have had laboratory testing for HIV infection, we will make every reasonable effort to obtain reports of the results of that testing. However, we will not purchase laboratory testing to establish whether you have HIV infection.

a. Definitive documentation of HIV infection. A definitive diagnosis of HIV infection is documented by one or more of the following laboratory tests:

(i) HIV antibody tests. HIV antibodies are usually first detected by an ELISA screening test performed on serum. Because the ELISA can yield false positive results, confirmation is required using a more definitive test, such as a Western blot or an immunofluorescence assay.

(ii) Positive "viral load" (VL) tests. These tests are normally used to quantitate the amount of the virus present but also document HIV infection. Such tests include the quantitative plasma HIV RNA, quantitative plasma HIV branched DNA, and reverse transcriptase-polymerase chain reaction (RT-PCR).

(iii) HIV DNA detection by polymerase chain reaction (PCR).

(iv) A specimen that contains HIV antigen (for example, serum specimen, lymphocyte culture, or cerebrospinal fluid).

(v) A positive viral culture for HIV from peripheral blood mononuclear cells (PBMC).

(vi) Other tests that are highly specific for detection of HIV and that are consistent with the prevailing state of medical knowledge.

b. Other acceptable documentation of HIV infection. We may also document HIV infection without the definitive laboratory evidence described in 14.00F1a**, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence in your case record. If no definitive laboratory evidence is available, we may document HIV infection by the medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence. For example, we will accept a diagnosis of HIV infection without definitive laboratory evidence of the HIV

infection if you have an opportunistic disease that is predictive of a defect in cell-mediated immunity (for example, toxoplasmosis of the brain, Pneumocystis pneumonia (PCP)), and there is no other known cause of diminished resistance to that disease (for example, long-term steroid treatment, lymphoma). In such cases, we will make every reasonable effort to obtain full details of the history, medical findings, and results of testing.

2. CD4 tests. Individuals who have HIV infection or other disorders of the immune system may have tests showing a reduction of either the absolute count or the percentage of their T-helper lymphocytes (CD4 cells). The extent of immune suppression correlates with the level or rate of decline of the CD4 count. Generally, when the CD4 count is below 200/mm3 (or below 14 percent of the total lymphocyte count) the susceptibility to opportunistic infection is greatly increased. Although a reduced CD4 count alone does not establish a definitive diagnosis of HIV infection, a CD4 count below 200 does offer supportive evidence when there are clinical findings, but not a definitive diagnosis of an opportunistic infection(s). However, a reduced CD4 count alone does not document the severity or functional consequences of HIV infection.

3. Documentation of the manifestations of HIV infection. The medical evidence must also include documentation of the manifestations of HIV infection. Documentation may be by laboratory evidence or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

a. Definitive documentation of the manifestations of HIV infection. The definitive method of diagnosing opportunistic diseases or conditions that are manifestations of HIV infection is by culture, serologic test, or microscopic examination of biopsied tissue or other material (for example, bronchial washings). We will make every reasonable effort to obtain specific laboratory evidence of an opportunistic disease or other condition whenever this information is available. If a histologic or other test has been performed, the evidence should include a copy of the appropriate report. If we cannot obtain the report, the summary of hospitalization or a report from the treating source should include details of the findings and results of the diagnostic studies (including appropriate medically acceptable imaging studies) or microscopic examination of the appropriate tissues or body fluids.

b. Other acceptable documentation of the manifestations of HIV infection. We may also document manifestations of HIV infection without the definitive

laboratory evidence described in 14.00F3a, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence in your case record. For example, many conditions are now commonly diagnosed based on some or all of the following: Medical history, clinical manifestations, laboratory findings (including appropriate medically acceptable imaging), and treatment responses. In such cases, we will make every reasonable effort to obtain full details of the history, medical findings, and results of testing. The following are examples of how we may document manifestations of HIV infection with other appropriate evidence.

(i) Although a definitive diagnosis of PCP requires identifying the organism in bronchial washings, induced sputum, or lung biopsy, these tests are frequently bypassed if PCP can be diagnosed presumptively. Supportive evidence may include: Fever, dyspnea, hypoxia, CD4 count below 200, and no evidence of bacterial pneumonia. Also supportive are bilateral lung interstitial infiltrates on x-ray, a typical pattern on CAT scan, or a gallium scan positive for pulmonary uptake. Response to anti-PCP therapy usually requires 5-7 days, and such a response can be supportive of the diagnosis.

(ii) Documentation of Cytomegalovirus (CMV) disease (14.08D) may present special problems because definitive diagnosis (except for chorioretinitis, which may be diagnosed by an ophthalmologist or optometrist on funduscopic examination) requires identification of viral inclusion bodies or a positive culture from the affected organ and the absence of any other infectious agent likely to be causing the disease. A positive serology test does not establish a definitive diagnosis of CMV disease, but does offer supportive evidence of a presumptive diagnosis of CMV disease. Other clinical findings that support a presumptive diagnosis of CMV may include: Fever, urinary culture positive for CMV, and CD4 count below 200. A clear response to anti-CMV therapy also supports a diagnosis.

(iii) A definitive diagnosis of toxoplasmosis of the brain is based on brain biopsy, but this procedure carries significant risk and is not commonly performed. This condition is usually diagnosed presumptively based on

symptoms or signs of fever, headache, focal neurologic deficits, seizures, typical lesions on brain imaging, and a positive serology test.

(iv) Candidiasis of the esophagus (also known as Candid a esophagitis) may be presumptively diagnosed based on symptoms of retrosternal pain on swallowing (odynophagia) and either oropharyngeal thrush (white patches or plaques) diagnosed on physical examination or by microscopic documentation of Candida fungal elements from a noncultured specimen scraped from the oral mucosa. Treatment with oral (systemic) antifungal agents usually produces improvement after 5 or more days of therapy, and such a response can be supportive of the diagnosis.

4. HIV infection manifestations specific to women.

a. General. Most women with severe immunosuppression secondary to HIV infection exhibit the typical opportunistic infections and other conditions, such as PCP, Candida esophagitis, wasting syndrome, cryptococcosis, and toxoplasmosis. However, HIV infection may have different manifestations in women than in men. Adjudicators must carefully scrutinize the medical evidence and be alert to the variety of medical conditions specific to, or common in, women with HIV infection that may affect their ability to function in the workplace.

b. Additional considerations for evaluating HIV infection in women. Many of these manifestations (for example, vulvovaginal candidiasis, pelvic inflammatory disease) occur in women with or without HIV infection, but can be more severe or resistant to treatment, or occur more frequently in a woman whose immune system is suppressed. Therefore, when evaluating the claim of a woman with HIV infection, it is important to consider gynecologic and other problems specific to women, including any associated symptoms (for example, pelvic pain), in assessing the severity of the impairment and resulting functional limitations. We may evaluate manifestations of HIV infection in women under the specific criteria (for example, cervical cancer under 14.08E), under an applicable general category (for example, pelvic inflammatory disease under 14.08A4) or, in appropriate cases, under 14.08K.

5. Involuntary weight loss. For purposes of 14.08H, an involuntary weight loss of at least 10 percent of baseline is always considered “significant.” Loss of less than 10 percent may or may not be significant, depending on the individual’s baseline weight and body

habitus. For example, a 7-pound weight loss in a 100-pound woman who is 63 inches tall might be considered significant; but a 14-pound weight loss in a 200-pound woman who is the same height might not be significant. HIV infection that affects the digestive system and results in malnutrition can also be evaluated under 5.08.

14.00I3. As used in these listings, "repeated" means that the manifestations occur on an average of three times a year, or once every 4 months, each lasting 2 weeks or more; or the manifestations do not last for 2 weeks but occur substantially more frequently than three times in a year or once every 4 months; or they occur less frequently than an average of three times a year or once every 4 months but last substantially longer than 2 weeks. Your impairment will satisfy this criterion regardless of whether you have the same kind of manifestation repeatedly, all different manifestations, or any other combination of manifestations; for example, two of the same kind of manifestation and a different one. You must have the required number of manifestations with the frequency and duration required in this section. Also, the manifestations must occur within the period covered by your claim.

5.08 Weight loss due to any digestive disorder despite continuing treatment as prescribed, with BMI of less than 17.50 calculated on at least two evaluations at least 60 days apart within a consecutive 6-month period.