NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES (NOSSCR)

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June 9, 2014

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Re: Comments on the ACUS study regarding SSA's policies for the evaluation of claimants' self-reported symptoms in the adjudication of Social Security disability claims

Dear Ms. Tatham:

Thank you for the opportunity to submit comments on the ACUS study of the Social Security Administration's (SSA) policies regarding the evaluation of self-reported symptoms in Social Security disability adjudication. We also want to thank you for the extension of time to respond to your questions.

To provide background about our organization, NOSSCR was founded in 1979 and is a professional association of attorneys and other advocates who represent individuals seeking Social Security disability and Supplemental Security Income (SSI) disability benefits. NOSSCR members represent these individuals at all Social Security Administration (SSA) administrative levels and in federal court. We are a national organization with a current membership of more than 4,000 members from the private and public sectors and are committed to the highest quality legal representation for claimants.

Our comments focus on the impact of the ACUS study on the millions of claimants and beneficiaries with severe disabilities for whom Title II and SSI cash benefits, along with the related Medicaid and Medicare benefits, are the means of survival. In conducting this study, it is important to keep in mind that SSA's policies for evaluating symptoms apply not only to allegations of pain but also to symptom evaluation of all nonexertional limitations, e.g., fatigue, environmental conditions, dizziness, and limitations caused by mental impairments.

1. **What is the National Organization of Social Security Claimants' Representatives' position on SSA's current regulations for evaluating the credibility of a claimant's**

statements about his or her symptoms, including pain ("symptom evaluation regulations")? Evaluation of Symptoms, Including Pain, 56 Fed. Reg. 57,928 (adopted November 14, 1991) (codified at 20 C.F.R. §§ 404.1529, 416.929).

We believe that the current regulations and policies provide adequate detailed guidance for adjudicators and the public, allowing for accurate decision-making. They are measured and extensive, having been developed after years of comment and deliberation by SSA. The policies are sufficiently flexible to allow for application when a claimant's circumstances change.

Prior to 1991, SSA had failed to promulgate comprehensive rules for evaluation of symptoms. Under the policy in effect at the time, pain and other subjective symptoms, such as dizziness or numbness, were taken into account ***only*** if fully explained by laboratory or other diagnostic procedures. If not fully explained, debilitating pain, even where corroborated and credible, was discounted.

Section 3(a)(1) of "The Social Security Disability Benefits Reform Act of 1984," Pub. L. No. 98-460 (DBRA 1984), temporarily amended 42 U.S.C. § 423(d)(5):

> An individual's statement as to pain or other symptoms shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability.

This provision expired on December 31, 1986. The Congressional conferees in 1984 stated that the standard intended to codify SSA's policy on pain at that time. After multiple court cases challenged the standard used by SSA to evaluate pain, the courts stepped in to fill the void caused by SSA's failure to promulgate comprehensive rules for evaluating subjective symptoms like pain. The circuit courts established an extensive collection of precedent in this area.[1]

Precedent in different federal circuits shared a basic view: (1) If there is an underlying medical condition and the person's pain is "reasonably related" to that condition, then it must be considered; and (2) If the person's statements are found not credible, then the adjudicator must state the reasons.

The circuit case law played an important role in development of SSA's comprehensive regulations, issued in November 1991.[2] These regulations drew from the body of case law in

[1] *See, e.g., Luna v. Bowen*, 834 F.2d 161 (10th Cir. 1987); *Polaski v. Heckler*, 739 F.2d 1320 (8th Cir. 1984).
[2] 56 Fed. Reg. 57928 (Nov. 14, 1991). The notice of proposed rulemaking was published in September 1988. 53 Fed. Reg. 35516 (Sept. 14, 1988).

providing a detailed framework for evaluating subjective symptoms, including pain. The summary to the final rule states:

> These expanded regulations incorporate the terms of the statutory standard for evaluating pain and other symptoms contained in section 3 of the Social Security Disability Benefits Reform Act of 1984 (Pub. L. 98-460).

The preface to the final rule explains:

> The policy for the evaluation of pain and other symptoms, as expressed in the statutory standard and clearly set forth in these final rules, requires that: (1) For pain or other symptoms to contribute to a finding of disability, an individual must first establish, by medical signs and laboratory findings, the presence of a medically determinable physical or mental impairment which could reasonably be expected to produce the pain or other symptoms alleged; and (2) once such an impairment is established, allegations about the intensity and persistence of pain or other symptoms must be considered in addition to the medical signs and laboratory findings in evaluating the impairment and the extent to which it may affect the individual's capacity for work.[3]

The regulations have been followed and applied by the federal district and circuit courts. They have provided the type of guidance that adjudicators can easily follow, including a list of seven relevant factors:

- Daily activities;
- The location, duration, frequency, and intensity of pain or other symptoms;
- Precipitating and aggravating factors;
- The type, dosage, effectiveness, and side effects of any medication;
- Treatment, other than medication, the claimant receives or have received for relief of pain or other symptoms;
- Any measures the claimant uses or has used to relieve pain or other symptoms, e.g., lying flat on his/her back, standing for 15 to 20 minutes every hour, and/or sleeping on a board; and
- Other factors concerning the claimant's functional limitations and restrictions due to pain or other symptoms.[4]

2. What is the National Organization of Social Security Claimants' Representatives' position on SSA's current sub-regulatory guidance for evaluating the credibility of a claimant's statements about his or her symptoms, including pain ("symptom evaluation guidance")? SSR 96-7p, 61 Fed. Reg. 34,483 (July 2, 1996).

[3] 56 Fed. Reg. 57928.
[4] 20 C.F.R. §§ 404.1529(c)(3) and 416.929(c)(3).

We believe that the policies in SSR 96-7p and other relevant policy SSRs provide detailed guidance to SSA adjudicators and to the courts in applying the regulations on evaluation of symptoms and determining credibility.

On July 2, 1996, SSA issued a series of nine Social Security Rulings intended to provide consistent policy guidance at all adjudicative levels regarding important disability policy issues.[5]

SSR 96-7p addresses "Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements."[6] It is important to note that other 1996 policy SSRs address pain and symptoms, including: SSR 96-3p, "Allegations of Pain and Other Symptoms in Considering Whether an Impairment is "Severe,"[7] and SSR 96-4p, "Symptoms, Medically Determinable Impairments, and Exertional/Nonexertional Limitations."[8]

SSR 96-7p clarifies evaluation of symptoms including pain, under the requirements set forth in 20 C.F.R. §§ 404.1529 and 416.929, which require a finding of credibility of statements about pain and other symptoms and the functional effects. The SSR includes the seven factors set forth in the regulations to be considered by the adjudicator, in addition to the objective medical evidence when assessing the credibility of the claimant's statements.

SSR 96-7p provides a level of detail in its guidance beyond that in the regulations. Some of the topics covered on credibility include the following:

- The extent to which statements about symptoms can be relied upon depends on the credibility of the statements.

- The credibility finding cannot be based on an intangible or intuitive notion about credibility. Reasons must be (1) specific; (2) based on the evidence in the record; and (3) specifically stated in the decision to make the credibility finding clear to the individual and subsequent reviewers. It is not sufficient to make conclusory statements like "individual's allegations have been considered" or that "the allegations are not credible," or to simply list the seven factors in the regulations.

- The adjudicator may find all, some, or none of the individual's allegations to be credible or find statements credible to a certain degree. This may mean that statements are "partially credible," because the abilities are compromised but not to the degree alleged ***or*** because the limitations may be greater than that stated by the individual. The SSR emphasizes that a finding of "not credible" cannot be solely relied upon to find a claimant "not disabled."

In addition to the seven factors in the regulations, the SSR provides additional guidelines to be considered in evaluating credibility such as consistency with other information in the record.

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[5] Social Security Rulings (SSRs) are published in the Federal Register and are binding on all SSA components. "These rulings represent precedent final opinions and orders and statements of policy and interpretations that we have adopted." 20 C.F.R. § 402.35(b)(1).
[6] 61 Fed. Reg. 34483 (July 2, 1996).
[7] 61 Fed. Reg. 34468.
[8] 61 Fed. Reg. 34488.

SSR 96-7p also discusses the relationship between statements about symptoms and objective medical evidence of pain, which had been SSA's policy prior to DBRA 1984 and much of the pre-1991 litigation. The SSR emphasizes that allegations about the intensity and persistence of pain or other symptoms "may not be disregarded *solely* because they are not substantiated by objective medical evidence."[9] (emphasis in original) Other guidance on medical information includes:

- The need for description of symptoms over time.
- Longitudinal record of treatment, its success or failure, including side effects of medication. Longitudinal medical evidence is "extremely valuable."
- Indications of other impairments, e.g., mental impairments, which could account for the allegations.
- Medical treatment history, including treatment which may cause other symptoms as a side effect. Also, it is emphasized that adjudicators not draw any inference from a failure to seek or pursue regular treatment without first considering explanations, such as the need to structure activities to avoid exacerbation of symptoms; prescribed medication is not taken because of the side effects; the individual may not be able to afford treatment; or medical treatment may be contrary to the claimant's religious beliefs.

3. What suggestions does the National Organization of Social Security Claimants' Representatives have, if any, for improving SSA's current symptom evaluation regulations and/or guidance?

We believe that additional training or "reminders" about the guidance provided in the regulations and SSRs would be useful. Through our members, we review many Appeals Council and court decisions, and one of the most frequent issues is the improper application of SSA policy. The policy is clear yet the adjudicator misapplies or even ignores the requirement(s). These are some examples from our members:

- The district court remanded the case because the ALJ erroneously found that the claimant's congestive heart failure (CHF) was not a "severe impairment" at step 2. (The plaintiff died of a heart attack while the appeal was pending.) The court found that "the ALJ committed legal and factual error in discounting Claimant's symptoms based upon his failure to obtain regular medical treatment." The plaintiff lacked the financial ability or insurance coverage necessary to obtain ongoing care after his employment ended. Under SSR 96-7p, the ALJ cannot draw adverse credibility inferences based on failure to seek regular medical treatment without first considering the claimant's explanations. Medical reports in the record confirmed how the lack of insurance negatively impacted the ability to obtain adequate medical care. There was no evidence that the ALJ actually considered the plaintiff's financial resources.[10]

[9] 61 Fed. Reg. at 34487.
[10] *Russell o/b/o Roach*, Case No. 1:10-cv-746 (S.D.Ohio Dec. 16, 2011).

- The court remanded the case because the ALJ improperly evaluated Plaintiff's pain. The court stated that "[from] the medical records as well as from [Plaintiff's] testimony, there are many indicia that [Plaintiff's] pain might limit her capabilities. The ALJ, however, found that [Plaintiff's] pain would not limit her RFC because [Plaintiff's] testimony was not credible." The court reasoned that the ALJ's "credibility determination cannot be based on an intangible or intuitive notion about the individual's credibility . . . the reasons for the credibility finding must be grounded in the evidence and articulated in the decision." The ALJ failed to explain or support her credibility analysis with any facts; instead, she merely concluded that Plaintiff's statements were not credible because they are inconsistent with the RFC determination. The court stated:

> The ALJ's analysis is circular: the only reason [Plaintiff] did not have a lower functional capacity was because her pain testimony was deemed not credible. If the ALJ found [Plaintiff's] testimony to be credible, then her RFC would have been at a lower functional capacity. The ALJ does not identify the medical or other evidence in the record which undermines the intensity, persistence and limiting effects of her pain and other symptoms about which [Plaintiff] complains.[11]

4. What legal or practical concerns does the National Organization of Social Security Claimants' Representatives have, if any, regarding the symptom evaluation regulations and/or guidance as applied within the SSA adjudicatory process and as reviewed by the federal courts?

The current regulations require adjudicators to apply a two-step process: (1) Medical signs and laboratory findings must establish an underlying medically determinable impairment that could reasonably be expected to produce the individual's pain or other symptoms; and (2) Once that impairment is established, then the adjudicator must evaluate the intensity, persistence, and limiting effects of the individual's symptoms.[12] "When evaluating the credibility of an individual's statements, the adjudicator must consider the entire case record and give specific reasons for the weight given to the individual's statements."[13]

We review hundreds of district court and circuit court cases involving Social Security and SSI disability claims every year, with many decisions resulting in court-ordered remands. One of the most frequent reason for the remands is the ALJ's failure to properly apply this two-step evaluation and the failure to properly articulate the weight given to the claimant's statements.

One important circuit court case exemplifies this problem with an ALJ's finding (or a variation thereof) that "[t]he claimant's statements concerning the intensity, persistence, and limiting effects of her symptoms are not entirely credible to the extent they are inconsistent with the above residual functional capacity (RFC) assessment." The United States Court of Appeals for the Seventh Circuit issued two opinions, holding that this type of "boilerplate" language is

[11] *Pusey v. Astrue*, Civil No. SKG-09-3410 (D.Md. Feb. 14, 2011).
[12] 20 C.F.R. §§ 404.1529(b) and (c), 416.929(b) and (c).
[13] SSR 96-7p, 61 Fed. Reg. 34485.

"meaningless and unhelpful to a reviewing court." *Bjornson v. Astrue*, 671 F.3d 640 (7th Cir. 2012); *Smith v. Astrue*, 467 Fed. Appx. (7th Cir. 2012).

In *Bjornson*, Circuit Judge Posner chastised SSA for its repeated use of this "template" language, as it was described in the government's brief, which had been criticized previously by the Seventh Circuit and by other courts. Calling this "meaningless boilerplate," the statement that a witness's testimony "is not entirely credible" provides no basis to determine what weight the ALJ gave the testimony. Such conclusory statements fail to provide a link to evidence in the record or even tailoring the language to the case at hand.

Adding to the credibility language the statement: "to the extent they [the symptoms] are inconsistent with the above RFC assessment" is "even worse, though the government's brief defends it with great vigor …." The court continued:

> The government regards the "template" as an indispensable aid to the Social Security Administration's overworked administrative law judges. Yet when we asked the government's lawyer at argument what the "template" means, he confessed he did not know.

671 F.3d at 645. What is the substantive problem with this "template" language? The RFC assessment/finding comes later in the decision process, after there is a credibility finding:

> A deeper problem is that the assessment of a claimant's ability to work will often (and in the present case) depend heavily on the credibility of her statements concerning the "intensity, persistence and limiting effects" of her symptoms, but the passage implies that ability to work is determined first and is then used to determine the claimant's credibility. That gets things backwards.

Id. The court notes the "tension" between the boilerplate/template language and SSR 96-7p, which requires credibility to be considered in determining the RFC. As a result, Judge Posner chides SSA: "The Social Security Administration had better take a close look at the utility and intelligibility of its 'templates.'" *Id.* at 646.

The court then reviewed the opinions of three examining physicians, which the ALJ mischaracterized as not supporting Bjornson's credibility. In fact, the court found that these reports and opinions were generally consistent with her testimony. The court pointed out several groundless reasons for finding these opinions did not support the claimant's subjective complaints. First, the ALJ said one physician's report was based on sympathy. The court found this "both unsupported and implausible" as the claimant is not his patient - he was a consultative examiner. A treating doctor said that the claimant must sit or lie down several times a day to control her pain, which was consistent with the claimant's testimony. The ALJ interpreted this to mean that the claimant could perform sedentary work as long as she had a sit-stand option. The court outright rejected this: "One does sedentary work sitting (the word 'sedentary' is from the Latin word '*sedere,*' which means 'to sit'), but not lying down."

The court also put to rest the frequent finding that a claimant is not credible because she can perform activities of daily living. "[S]he had never testified that she was immobilized, and

indeed she had testified that she had one or two good days each week …." With activities of daily living, rather than work activities, the individual has more flexibility in scheduling, can get help from others, and is not held to a minimum standard of performance. "The failure to recognize these differences is a recurrent, and deplorable, feature of opinions by administrative law judges in social security disability cases."

In *Smith v. Astrue,* decided about six weeks after *Bjornson*, the Appellant again contested "the ALJ's use of the boilerplate statement that 'the claimant's statements concerning the intensity persistence and limiting effects' of her symptoms 'are not credible to the extent they are inconsistent with the above residual functional capacity assessment.'" The court agreed:

> Smith's argument on this point is well-taken. We have derided repeatedly this sort of boilerplate as meaningless and unhelpful to a reviewing court. *See Bjornson v. Astrue* (citations omitted) … This boilerplate is especially unhelpful because it "implies that the ability to work is determined first and is then used to determine the claimant's credibility. That gets things backwards." *Bjornson* (citation omitted) … Often, as here, the assessment of the claimant's ability to work depends at least in part on the credibility of the claimant's testimony regarding the intensity of her symptoms. *See id.* And while the subsequent paragraphs of the ALJ's opinion tick off certain medical evidence, this account does not specify how the evidence undermines Smith's credibility or which statements the ALJ found not credible … Because the ALJ did not support her credibility determination with reference to specific record evidence, we cannot assess whether the credibility determination was "patently wrong." *See Schaaf v. Astrue*, 602 F.3d 869, 875 (7th Cir. 2010).

In both cases, the Seventh Circuit remanded the cases for further proceedings consistent with the opinions.

The following cases also demonstrate the important role of the federal courts in assuring that SSA's rules and regulations on symptom evaluation are properly applied by its adjudicators:

- **ALJ failure to explain rationale for discrediting the claimant**. "Because the ALJ did not provide good reasons for discrediting Comstock's subjective complaints regarding the effects of her migraines, I find that remand is necessary for the ALJ to reevaluate the credibility of these complaints and further develop the record, if necessary. On remand, the ALJ shall set forth in detail her reasons for finding Comstock's subjective complaints to be credible or not credible. If the ALJ finds Comstock's complaints to be not credible, she shall fully explain the reasons and/or inconsistencies for her credibility determination." [14]

• **Lack of specificity to allow for judicial review.** The court remanded the case because the ALJ's assessment of the plaintiff's credibility "does not allow judicial review." The ALJ considered the plaintiff's complaints of pain, finding that it limited him to a sedentary RFC. However, the ALJ's conclusions implied that he rejected the plaintiff's claim that his pain and other symptoms were totally disabling. It was unclear to the court why the ALJ rejected the plaintiff's testimony since the ALJ did not specify his reasons as required by the Third Circuit.

[14] *Comstock v. Astrue*, 923 F. Supp. 2d 1142 (N.D. Iowa 2013).

As a result, the ALJ failed to comply with his obligation to provide an adequate basis for the reviewing court to determine whether the decision was based on substantial evidence. The ALJ's finding that the plaintiff's "statements concerning the intensity, persistence and limiting effect of [his] symptoms are not credible to the extent they are inconsistent with the above [sedentary RFC] assessment is just not specific enough to allow for judicial review without further explanation."[15]

5. What factors would the National Organization of Social Security Claimants' Representatives suggest that the SSA disability determination process take into account in evaluating a claimant's statements about his or her symptoms, including pain?

We believe that the current policy – regulations and Social Security Rulings – provide appropriate and relevant factors for evaluating a claimant's symptoms, including pain.

Additionally, in our response to Question 8 below, we discuss several other SSA policies that are relevant to the evaluation of symptoms, including pain, in the Social Security disability determination process, e.g., the weight given to medical opinion, the weight given to non-physician medical sources, and the weight given to non-medical sources.

6. What findings, if any, would the National Organization of Social Security Claimants' Representatives suggest that adjudicators make in evaluating a claimant's statements about his or her symptoms, including pain? What type of support should underlie such findings?

We believe that the current policy – regulations and Social Security Rulings – provide appropriate and relevant guidelines for evaluating a claimant's symptoms, including pain. The policy explains what factors must be considered and what support is needed for findings made by adjudicators.

7. Does the National Organization of Social Security Claimants' Representatives have any additional comments or views it would like to share on the SSA's current process for evaluating a claimant's statements about his or her symptoms, including pain?

It is critical that SSA provide adequate support and guidance to adjudicators regarding the application of its policies for evaluation of symptoms, including pain. As discussed in our responses to other Questions, including Questions 3, 4, and 9, we often see misapplication of SSA's policies, leading to erroneous denials and lengthening the process for claimants who must then appeal.

[15] *Colon v. Commissioner of Social Security*, Civil Action No. 12-4870 (JLL)(D.N.J. Nov. 19, 2013).

8. What suggestions does the National Organization of Social Security Claimants' Representatives have, if any, for improving SSA's treatment of pain in the disability determination process (*e.g.* , in evaluating the existence of an impairment, evaluating opinion evidence, assessing residual functional capacity, or in determining whether a claimant's impairment imposes exertional and/or nonexertional limitations)?

We want to emphasize the importance of appropriate training and guidance for SSA adjudicators regarding evaluation of symptoms, including pain. This includes the proper application of other important SSA policies, such as those discussed below, which are often part of the adjudicator's evaluation of symptoms.

A. ALJ failure to properly weigh medical evidence. A common error in discrediting a claimant's testimony, found by the Appeals Council and federal courts, is the ALJ's failure to properly weigh the medical evidence regarding the claimant's impairments and limitations. This is a necessary component to evaluate the claimant's credibility. Statements about pain or other symptoms will not alone establish disability – there must be medical evidence to establish the existence of an impairment which could "reasonable be expected to produce the pain or other symptoms alleged …." [16] In addition, the claimant's allegations must "reasonably be accepted as consistent" with the medical evidence of record.

The current regulations require adjudicators to "evaluate every medical opinion we [i. e., SSA] receive" when determining the weight to give these opinions, including those from treating sources.[17] The regulations also require adjudicators to "consider all of the … factors [in the regulations] in deciding the weight we give to any medical opinion"[18] and to "make findings about what the evidence shows."[19] Consistent with the second guiding principle for the regulations, the courts have required adjudicators to provide a rationale, explaining how the factors were applied to determine the weight given to medical opinions and to provide valid reasons for discounting or rejecting the opinions of treating sources.

In our review of district court and circuit court cases involving Social Security and SSI disability claims, the most frequent reason for the remands is the ALJ's failure to articulate supported and valid reasons for rejecting or discounting medical evidence from treating sources.

SSA's regulations require that "[w]e will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion."[20] The failure to provide a rationale leaves the court unable to adequately review the record since the court cannot determine how the ALJ weighed the evidence or why the ALJ may have rejected an opinion. As a result, the court has no choice but to remand the case for further development of the record.

[16] 20 C.F.R. §§ 404.1529(a) and 416.929(a).
[17] 20 C.F.R. §§ 404.1527(d) and 416.927(d).
[18] *Id.*
[19] 20 C.F.R. §§ 404.1527(c) and 416.927(c).
[20] 20 C.F.R. §§ 404.1527(d)(2) and 416.927(d)(2).

For example, a district court remanded a case under sentence four of 42 U.S.C. § 405(g). The ALJ erred in finding the plaintiff not fully credible. First, there was no contradiction in the plaintiff's hearing testimony regarding activities of daily living. Second, there was no contradiction between the treating doctor's findings regarding lower back pain and a clinic visit two months later for a different impairment. In context, it was not reasonable to discount the treating doctor's finding that the plaintiff was limited in ability to walk, stand, sit, and lift, based on the clinic's ambiguous note. Third, the ALJ found inconsistencies in the treating doctor's findings, yet he did not seek clarification from the doctor. The "ALJ has failed to point out any legitimate inconsistencies in the record that would permit a finding of a lack of credibility."[21]

In another case, the district court remanded for an award of benefits. First, the ALJ's reasons for rejecting the treating doctor's report based on "purported" inconsistencies lacked "specificity and legitimacy required to reject the conclusions of a treating physician…." The court rejected the negative credibility evaluation by the ALJ. The court rejected the ALJ's examples of inconsistencies between the plaintiff's testimony and the medical evidence, since they were not supported by substantial evidence. If there is a condition that is "capable of causing pain," then under Ninth Circuit case law, the ALJ cannot only look to the absence of objective findings to degrade the claimant's credibility. There were objective findings in this case, but the heart of the case is that the testimony was "credited as true," such that remand was not the remedy, but rather payment of benefits.[22]

B. Opinions by non-physician treating sources. NOSSCR recommends that SSA expand the definition of "acceptable medical source" to include a broader range of primary treating sources, specifically nurse practitioners, physician assistants, and clinical social workers, who are all licensed and credentialed under state law. We support ACUS's Administrative Conference Recommendation 2013-1, Section 6: "Recognizing the Value of Other Medical Sources."[23]

Under the SSA regulations, only an "acceptable medical source" can establish the existence of a "medically determinable impairment."[24] SSA considers evidence from "acceptable medical sources" to be "medical opinions" subject to the "treating source" rule.[25]

SSA should expand the list of "acceptable medical sources" to include nurse practitioners, physician assistants, and clinical social workers, who are all licensed and credentialed under state law. Delays in the disability claims process often arise when SSA requires a consultative examination to confirm the diagnosis made by a nurse practitioner, physician assistant, or licensed clinical social worker.

Millions of Americans now rely on these licensed practitioners as their primary providers of physical and mental health care. Based on current trends, these health professionals will become an increasing part of the nation's healthcare workforce – a role that the federal government is committed to promoting. Because these professionals are licensed by states, expanding the list

[21] *Lowery v. Astrue*, No. 4:11CV00345 JLH/HDY (E.D.Ark. Oct. 29, 2012).
[22] *Free v. Commissioner*, Civ. No. 1:12-cv-00601-AC (D.Ore. June 7, 2013).
[23] 78 Fed. Reg. 41352, 41354 (July 10, 2013). Our support for Administrative Conference Recommendation 2013-1 is limited to Section 6 only.
[24] 20 C.F.R. §§ 404.1513(a) and 416.913(a).
[25] 20 C.F.R. §§ 404.1527(d) and 416.927(d); 20 C.F.R. §§ 404.1527(d)(2) and 416.927(d)(2).

of acceptable medical sources to include them protects the integrity of the disability programs. Most importantly, it will streamline the process, ensuring that eligible individuals access benefits in a timely manner.

In a case that demonstrates the problem with the current policy,[26] the court found that the ALJ's rejection of Plaintiff's nurse practitioner's opinion was not supported by substantial evidence. The ALJ stated that "[while Plaintiff's nurse practitioner] may have been able to manage the claimant's medical care in general, the record does not reflect that she was able to provide any more care than simply reacting to the claimant's latest crisis." The court found that there was no evidence in the record that supported the ALJ's "speculation" that Plaintiff's nurse practitioner was "reacting to a crisis" as opposed to her professional judgment when she rendered medical assistance or, more importantly, when she completed her reports which support greater limitations than those found by the ALJ. The court stated that such "speculation on the part of the ALJ is improper." The court added:

> The ALJ acknowledged [the nurse practitioner's] opinions, but rejected them on a basis that inaccurately describes the factual record. Contrary to what the ALJ stated, the record contains numerous pages of detailed treatment notes from [the nurse practitioner's] office where there are several notations of Plaintiff losing her insurance and her inability to pay for medications, as well as notations of her problems with depression, hypertension, breathing and exacerbations – while she was taking medications . . . [the Court found] only 3 notations of [the nurse practitioner] discussing 'compliance' with her patient in the two and a half years that she treated Plaintiff. This hardly supports a finding that it is a record replete with the non-compliance, as the ALJ described.

C. Evidence from sources who are not "acceptable medical sources." The fact that SSA has established a distinction between evidence from physician and non-physician sources, and "medical sources" and "other sources" allows adjudicators to consider non-physician evidence to be less important, even though provided by licensed health professionals. As a result, some adjudicators give it less weight than it deserves, despite the fact that it is the key information needed to establish the individual's functional limitations.

SSA has recognized the importance of this evidence from non-physician sources and made a strong policy statement to that effect in SSR 06-3p, "Considering Opinions and Other Evidence From Sources Who Are Not 'Acceptable Medical Sources' in Disability Claims."[27] While SSR 06-3p provides guidance for evaluation of medical information from non-physician professionals, which is often crucial to the claim, it is not often well applied by adjudicators. The following cases demonstrate the role of SSR 06-3p and how it should be properly applied:

- The court concluded that under SSR 06-3p, the ALJ "was obligated to provide a more detailed explanation for his decision to reject the opinions of the [treating] physician assistant … the medical professional with arguably the most detailed knowledge of claimant's condition, her treatment, and her response to that treatment." The ALJ has discretion but must still give "at least a brief and sufficient explanation" for giving less weight to that evidence. In this case, the

[26] *Neely v. Astrue*, Case No. PWG-09-523 (D.Md. Sept 30, 2010).
[27] 71 Fed. Reg. 45593 (Aug. 9, 2006).

ALJ stated that the physician assistant was not an "acceptable medical source" and then concluded that "her opinions are not supported by the medical evidence on the record." Based on this meager statement, he gave her opinions "little weight." The court found that "[h]ere, the ALJ's reasons for rejecting [the treating physician assistant's] opinions are not sufficiently detailed to permit meaningful appellate review." The case was remanded for further proceedings.[28]

- In a January 2011 decision, the Appeals Council remanded the case because the ALJ failed to evaluate the third party statement submitted by the claimant's husband. Evidence from "other sources" including friends and relatives can be used to show the severity of the claimant's impairments per 20 C.F.R. §§ 404.1513(d) and 416.913(d). SSR 06-3p states that the adjudicator should explain the weight given to opinions from "other sources."

- The district court remanded for further consideration of Listing 12.04C. The ALJ erred in finding that the plaintiff's depression and bipolar disorder did not meet Listing 12.04C. The plaintiff resided in a community mental health program residence. The ALJ said she lived there because she could not afford another residence, but her psychiatrist recommended she live there. The plaintiff's community support advocate stated that the plaintiff needed the support services of the organization indefinitely. The ALJ erred in relying on SSR 06-3p to give the community support advocate's opinion little weight because she was not a medical professional. The SSR says that these sources are to be given weight because of their personal knowledge.[29]

- The district court remanded the case because the ALJ erred in disregarding evidence from the plaintiff's counselor, a non-medical treating source, and failing to articulate the reasons as required by SSR 06-3p. The counselor had provided evidence that the plaintiff had eleven "marked" or "extreme" limitations in the areas of concentration and persistence and adapting to the work setting, due to sleep apnea and anxiety. The treating physician had expressed a similar opinion regarding the plaintiff's mental RFC. While the counselor's opinion is not entitled to either controlling or substantial weight under 20 C.F.R. § 404.1527(d), "that does not mean that such opinions can be totally disregarded." SSR 06-3p states that information from non-medical treating sources, such as social workers and therapists, must be reviewed and evaluated using the same factors in the regulation. The ALJ must explain the weight given to the opinion from these sources or at least discuss the evidence and provide a rationale. In this case, the only basis for rejecting the counselor's evidence in its totality is a "boilerplate recitation" that the Commissioner considered the evidence. No reasons specific to the counselor's evidence was given. The "primary deficiency" was the failure to articulate. "[S]ome of this failure constitutes a deviation from the Commissioner's own regulations or rulings …[T]he Commissioner ought to follow his own procedural regulations."[30]

[28] *Dumensil v. Astrue*, Civil No. 10-cv-060-SM (D.N.H. Aug. 4, 2010).
[29] *Handy v. Astrue*, Civil Action No. TMD 11-1317M (D.Md. May 4, 2012).
[30] *Ellinger v. Astrue*, Case No. 2:08-cv-986 (S.D.Ohio Jan. 27, 2010).

9. **Does National Organization of Social Security Claimants' Representatives believe that the changes in our understanding of acute and chronic pain, or in the medical assessment and treatment of acute and chronic pain, since the existing symptom evaluation regulations and guidance were adopted (early to mid-1990s) affect the basis or efficacy of the current symptom evaluation regulations and/or guidance? If so, why? If not, why not?**

As a membership organization with a focus on legal issues, our expertise is not in the medical assessment and treatment of pain.

* * *

Thank you for asking us to provide these comments.

Very truly yours,

Cynthia Berger
President, Board of Directors, NOSSCR

Barbara Silverstone
Executive Director, NOSSCR