NATIONAL ORGANIZATION OF
SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES
(NOSSCR)

560 Sylvan Avenue • Englewood Cliffs, NJ 07632
Telephone: (201) 567- 4228 • Fax: (201) 567-1542 • email: nosscr@att.net

Executive Director
Nancy G. Shor

June 10, 2011

Commissioner Michael J. Astrue
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235-6401

Submitted on www.regulations.gov

Re: Notice of Proposed Rulemaking on "How We Collect and Consider Evidence and Disability," 76 Fed. Reg. 20282 (Apr. 12, 2011); Docket No. SSA-2010-0044

Dear Commissioner Astrue:

These comments are submitted on behalf of the National Organization of Social Security Claimants' Representatives (NOSSCR).

Founded in 1979, NOSSCR is a professional association of attorneys and other advocates who represent individuals seeking Social Security disability or Supplemental Security Income (SSI) benefits. NOSSCR members represent these individuals with disabilities in legal proceedings before the Social Security Administration and in federal court. NOSSCR is a national organization with a current membership of more than 3,900 members from the private and public sectors and is committed to the highest quality legal representation for claimants. While our members represent claimants from the initial application through the Federal court appellate process, the majority of cases are hearings before Administrative Law Judges and appeals to the Appeals Council. However, many of our members do represent claimants at the initial and reconsideration levels.

Current regulations have adopted the "treating physician rule" and provide that medical evidence from treating sources will generally be given more weight. If certain requirements are met, treating physician opinions can be "controlling." 20 C.F.R. §§ 404.1527(d) and 416.927(d). We are very concerned that the changes proposed by this notice of proposed rulemaking (NPRM) will diminish the role and weight of medical evidence from treating physicians and treating sources. The most significant change of the NPRM is to remove the current requirement to recontact medical sources, particularly, treating sources.

Current Policy

The Social Security Act, 42 U.S.C. § 423(d)(5)(B), establishes the requirement to make "every reasonable effort" to obtain medical evidence from the claimant's treating physician before relying on evidence from a consultative examination (CE):

> … In making any determination the Commissioner of Social Security shall make every reasonable effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis.

This provision of the Act was enacted in 1984. Social Security Ruling 85-16 (1985) implemented the language in the Act in the context of residual functional capacity assessments for mental disorders:

> When medical source notes appear to be incomplete, recontact with the source *should be made* to attempt to obtain more detailed information. *Every reasonable effort should be made to obtain all medical evidence from the treating source* necessary to make a determination of impairment severity and RFC before obtaining evidence from any other source on a consultative basis (emphasis supplied).

In 1991, SSA promulgated regulations that implemented the 1984 statutory provision. 20 C.F.R. §§ 404.1512(e) and 416.912(e) require SSA to first recontact medical sources to obtain additional evidence or clarification in certain situations:

> (e)(1) We will first recontact your treating physician or psychologist or other medical source to determine whether the additional information we need is readily available. We will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques.

SSA "may" not recontact the source if "we know from past experience that the source either cannot or will not provide the necessary findings." *Id*. §§ 404.1512(e)(2) and 416.912(e)(2).

The Proposed Rule

The NPRM would delete 20 C.F.R. §§ 404.1512(e) and 416.912(e). Those sections would be revised and added to new sections 404.1520b and 416.920b: "How we consider evidence."

The new sections provide the following. After reviewing the evidence obtained, the adjudicator may not be able to make findings "because the evidence in your case record is insufficient or inconsistent." Evidence is "insufficient" when it does not contain all the information needed to make a decision. Evidence is "inconsistent" when it conflicts with other evidence, is internally

inconsistent, is ambiguous, or is not based on medically acceptable clinical or laboratory techniques.

In contrast to the current regulatory requirement, the NPRM would allow SSA, i.e., the adjudicator, to determine the best way to resolve the inconsistency or insufficiency. The NPRM preface says that SSA "expects" the adjudicator to first recontact the medical source. But, unlike the current regulations, this is not required and is in the discretion of the adjudicator. If left to their discretion, will adjudicators in many cases simply turn to other nontreating sources, namely, consultative examinations?

The NPRM preface says that based on "our adjudicative experience," "there are other, more effective, ways to obtain the additional information … It is sometimes inefficient and ineffective to require our adjudicators to first contact your medical source(s)." The examples given are when the treating source is not a specialist or when "issues revealed in the medical evidence are better clarified by someone other than your medical source(s)."

Concerns Raised by the NPRM

The NPRM would give more discretion to adjudicators. We do not believe that this will necessarily lead to more correct determinations. Given their time constraints, it seems that in many situations adjudicators will choose a route other than recontacting the treating source, for example, opting to obtain a consultative examination. Will this lead to lessening of role of the regulations dealing with the weight of medical opinion evidence? We are concerned that it will.

1. More discretion for adjudicators

Currently, adjudicators are required to recontact treating sources to resolve ambiguity or conflicts in the evidence they provide. 20 C.F.R. §§ 404.1512(e)(1) and 416.912(e)(1). The NPRM would delete that requirement, possibly conflicting with the statutory requirement in 42 U.S.C. § 423(d)(5)(B).

The NPRM preface states that SSA "expects" adjudicators would continue to recontact the claimant's medical sources "when we believe such recontact is the most effective and efficient way to resolve an inconsistency or insufficiency." 76 Fed. Reg. at 20283. However, given this level of discretion, how often will they recontact the treating sources? Will they find it easier to schedule a consultative examination? Will these efforts amount to "every reasonable effort" as required by the statute?

The current requirement is an important component of the process to obtain relevant medical information, especially from treating sources. A NOSSCR member told us that in some cases he requires his state agency to recontact a medical source prior to ordering a CE, by following the current regulations and relevant POMS. As a result, instead of virtually all of his clients being sent out for CEs, he has had only a few cases sent out at the initial or reconsideration levels over the last five or six months because the additional evidence was obtained from treating sources.

This example demonstrates the use of the current regulation requiring adjudicators to recontact treating sources, rather than unnecessarily expending limited funds to obtain consultative examinations.

In addition, it is troubling that the NPRM seems to give more importance to speed of adjudication, rather than making the correct decision at the earliest point possible, even if it may take longer. For instance, the NPRM preface notes that the requirement to recontact treating sources first "can sometimes cause a delay in the adjudication" of the case. It further states:

> This proposed change would give our adjudicators the discretion to determine the best way to address these issues and obtain the needed information more quickly. In these situations, we would shorten case processing time and conserve resources.

76 Fed. Reg. at 20283. While we generally support the goal of achieving increased efficiency throughout the adjudicatory process, we caution that limits must be placed on the goal of administrative efficiency for efficiency's sake alone. The purposes of the Social Security and SSI programs are to provide cash benefits to those who need them and have earned them and who meet the eligibility criteria. While there may be ways to improve the decision-making process from the perspective of the adjudicators, the bottom line evaluation must be how the process affects the very claimants and beneficiaries for whom the system exists.

2. Fewer cases where the treating source opinion is controlling

Under current regulations, a treating source's medical opinion will be given "controlling" weight if it is "well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record …." 20 C.F.R. §§ 404.1527(d)(2) and 416.927(d)(2).

Under the current regulations, the adjudicator is required to recontact treating sources to resolve inconsistencies or gaps in the evidence, as demonstrated in the example above. However, under the NPRM, there is no such requirement. As a result, we are concerned that the NPRM will lead to fewer cases where the treating source opinion is controlling since there could be fewer cases where those opinions are, in the opinion of the adjudicator, "well-supported" or where evidence is not inconsistent with other substantial evidence of record.

3. Fewer cases where treating source opinion is given greater weight

The NPRM preface provides these examples of when it is "inefficient and ineffective" to first recontact the treating source:

- A treating source "does not specialize in the area of the impairment you have alleged and we need more evidence about its current severity … [W]e may supplement the evidence in your case record by obtaining a CE with a specialist …." 76 Fed. Reg. at 20283.

- "[T]here are times when issues revealed in the medical evidence are better clarified by someone other than your medical source(s)." *Id*.

We are concerned that this will allow adjudicators to inappropriately circumvent the current regulations regarding the factors to weigh evidence for non-controlling opinions from treating sources.

The current regulations for weighing medical evidence provide that, if the treating source opinion is not controlling, it will still, generally, be given more weight than a nontreating source:

> Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations.

20 C.F.R. §§ 404.1527(d)(2) and 416.927(d)(2). When the opinion is not controlling, the adjudicator is required to apply the factors in paragraphs (d)(2)(i) and (ii), and the factors in paragraphs (d)(3) through (6). For example, more weight will be given to the treating source than a nontreating source, given the length of the treatment relationship and the frequency of examination. *Id*. § (d)(2)(i).

Another factor relates to the extent of knowledge the treating source has about the individual's impairment. "Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion … When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source." *Id*. § (d)(2)(ii).

Even in those cases where a treating source is not a specialist, he or she may still have "reasonable knowledge" of the impairment given the length of the treating relationship and the extent of the medical evidence provided. However, the NPRM preface infers that such "reasonable knowledge," obtained over years of treatment, could be ignored or given less weight in favor of a one-time CE by a nontreating source.

The current regulations for weighing medical evidence also provide that "supportability" is a factor in deciding whether to give the treating source opinion more weight. 20 C.F.R. §§ 404.1527(d)(3) and 416.927(d)(3). "The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion."

Under the NPRM, if the treating source evidence has gaps and needs more information to fill those gaps, the adjudicator has the discretion not to recontact the treating source and, instead, can rely on a nontreating source CE. Will this leave the treating source evidence less "supported" and thus given less weight?

4. Evidence that is specific and addresses disability determination criteria

The NPRM focuses on how SSA collects and considers evidence of disability. The preface talks about the advantages of electronic transmission of medical records, describing it as "dramatically improv[ing] the evidence collection process, particularly as it pertains to obtaining records from your medical source(s)." However, this does not directly translate into SSA and DDSs obtaining complete evidence from treating sources as it does not address the long-term problem of DDSs failing to obtain evidence that specifically addresses the criteria of the disability determination process.

The key to a successful disability claim is having adequate documentation. NOSSCR members find that a fully developed file is usually presented at the ALJ level because the claimant's representative has obtained evidence and/or because the ALJ has developed it. Often, this information was available earlier but was not requested.

Claimants' representatives are frequently able to obtain better medical information because they use letters and forms that ask questions relevant to the disability determination process. DDS forms usually ask for general medical information (diagnoses, findings, etc.) without tailoring questions to the Social Security disability standard. Electronic transmission of medical evidence will not address this long-term problem with development of the disability claim.

One way to address this would be for SSA to encourage DDSs to send Medical Source Statement forms to treating sources. These simple forms translate complex, detailed medical source opinions into practical functional terms useful to adjudicators.

Why are we so concerned about denials at the initial levels based on incomplete records? For a variety of reasons, many claimants denied at the initial level do not appeal to the reconsideration level, even though they may be as likely to be entitled to benefits as those who do appeal. We have long been concerned about claimants being discouraged from appealing denials and dropping out of the process.

* * *

For the reasons stated above, we urge SSA to reconsider the proposed change to eliminate the current requirement that adjudicators to first recontact treating sources before referring the claimant for a consultative examination by a nontreating source.

Thank you for consideration of our comments.

Sincerely,

Nancy G. Shor
Executive Director

Ethel Zelenske
Director of Government Affairs