NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES (NOSSCR)

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Executive Director
Barbara Silverstone

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Nancy Berryhill
Acting Commissioner
Social Security Administration
6401 Security Boulevard
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Submitted via www.regulations.gov

Re: Notice of Proposed Rulemaking on Revised Medical Criteria for Evaluating Musculoskeletal Impairments, 83 Fed. Reg. 20646 (May 7, 2018), Docket No. SSA-2006-0112

Dear Acting Commissioner Berryhill:

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

The National Organization of Social Security Claimants' Representatives (NOSSCR) is a specialized bar association for attorneys and advocates who represent Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) claimants throughout the adjudication process and in federal court. Founded in 1979, NOSSCR is a national organization with a current membership of more than 3,000 members from the private and public sectors and is committed to the highest quality representation for claimants and beneficiaries. NOSSCR's mission is to advocate for improvements in Social Security disability programs and to ensure that individuals with disabilities applying for SSDI and SSI benefits have access to highly qualified representation and receive fair decisions.

1.00 and 101.00 Musculoskeletal Disorders

Physical Examination Reports (Proposed 1.00C2 and 101.00C2)

We support the proposal to assume that medical sources performed tests properly unless there is evidence to the contrary. As noted in the example, this is important in situations like the straight-

leg raising test, where providers may not explicitly note that they tested the claimant in both seated and supine positions.

If reduction in muscle strength is a factor, the final rule should indicate that a 0 to 5 grading scale is allowable, but not required, for medical documentation. Alternative rating scales, such as the none/trace/poor/fair/good/normal scale used by Daniels and Worthingham and mentioned in Table 1, the percentage scale used by Kendall and McCreary, descriptions using the same or similar language as Table 1 of the proposed listing (e.g. "active ROM with gravity eliminated" or "active ROM w/o gravity" or other similar language should both be considered as equivalent to grade 2), should all be allowed.

Effects of Treatment (Proposed 1.00C5 and 101.00C5)

SSA regulations should never have the effect of encouraging certain treatments as a means of proving disability. Given the opioid crisis across the United States, many claimants make significant efforts to avoid opioid prescriptions or minimize the use of such drugs when prescribed; many medical providers are also attempting to use alternative treatments in lieu of opioids where possible. The final rule should explain here, and in 1.00D and 101.00D, that a lack of opioid prescription or attempts to reduce or avoid opioid use should never be considered indicative of the severity of a musculoskeletal impairment. Nor should it affect an adjudicator's decision about whether such impairments can reasonably be expected to produce a claimant's symptoms (including pain), or about the intensity and severity of such symptoms.

Assistive Devices (Proposed 1.00C6 and 101.00C6)

We support the proposed rule's statement that a prescription is not required for assistive devices. Disability claimants have a variety of financial and insurance situations that in some cases make prescribed devices unobtainable or more expensive. Whether a device is obtained via a prescription or "over the counter" does not affect a claimant's need for it.

The definition of "hand-held assistive devices" should also include wheelchairs and scooters. Although a wheelchair is not carried in the same way as canes, crutches, or unwheeled walkers, manual wheelchairs are pushed in a similar way to wheeled walkers and require the use of both hands to operate. Motorized wheelchairs and scooters may require the use of one or both hands to operate, or may be operated via other methods, such as sip-and-puff. Wheelchairs and scooters improve stability and mobility, and claimants with a documented medical need for a wheelchair or scooter require at least as much assistance in walking as those with a need for other assistive devices. The final rule should add wheelchairs and scooters along with canes, walkers, and crutches wherever such assistive devices appear, classifying them as one-handed or two-handed assistive devices according to how the claimant uses them.

Need for Assistive Devices versus "Inability to Ambulate Effectively" (Proposed 1.00E2 and 101.00E2)

The current listings offer the opportunity to establish disability without the need for a walker, bilateral canes, or bilateral crutches. They define an "inability to ambulate effectively" as "an

extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities." The need to use a two-handed assistive device is merely one example of an inability to ambulate effectively, with others including, but explicitly not limited to, "the inability to walk a block at a reasonable pace on rough or uneven surfaces, the inability to use standard public transportation, the inability to carry out routine ambulatory activities, such as shopping and banking, and the inability to climb a few steps at a reasonable pace with the use of a single hand rail."

SSA offers no explanation for this remarkable change. Individuals who cannot climb a few steps without use of a handrail, walk a block at a reasonable pace on a surface with some texture, or perform routine activities have significant limitations and are extremely likely to be found disabled at steps 4 and 5 of the sequential evaluation process. This is why the current listings allow for a finding of disability at step 3 of the process: because it would be inefficient for adjudicators to continue to subsequent steps in the process when the outcome would ultimately be the same. The National Association of Disability Examiners' (NADE's) 2002 comments on proposed changes to musculoskeletal listings made this point in considerable detail:

> **We strongly dispute any suggestion by SSA that adjudicating claims at steps four and five in the sequential evaluation process can be done as quickly and as efficiently as claims decided earlier in the process.** It is far easier and less time consuming to process claims earlier in sequential evaluation when only medical factors are considered. Claims that require subjective consideration of functional abilities and other vocational factors will require more time to develop than claims that are decided on the basis of objective medical factors alone. SSA is ignoring reality to believe otherwise….**If, as expected, the revised listings result in more decisions at steps four and five of sequential evaluation, then this will clearly result in more development costs and increased processing time**.[1]

All portions of the proposed listings that discuss a medical need for an assistive device should instead include the "inability to ambulate effectively" standard from the current listings. In addition, SSA should consider NADE's comments and the effect on processing time at all points in the proposed listings that would decrease awards at the listing stage of the sequential evaluation process and require adjudicators to make additional findings.

Obesity (Current Listing 1.00Q)

The proposed rule eliminates 1.00Q, the discussion of obesity and the impact it has on musculoskeletal impairments. SSA does not justify this change. Obesity clearly intensifies the effects of such impairments[2] and can change what treatments are appropriate or effective. As recognized in SSR 02-1p, "the combined effects of obesity with other impairments, specifically musculoskeletal impairments, can be greater than the effects of each of the impairments considered separately." SSA has not cited any authority to support that this premise is no longer true to justify removal of the policy in 1.00Q.

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[1] https://www.regulations.gov/document?D=SSA-2006-0112-0007**,** emphasis in original

[2] See, e.g., https://www.ncbi.nlm.nih.gov/pubmed/19093327 and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4792212/

An increasing number of working age Americans are obese[3], as are an increasing percentage of disability claimants.[4] Obese claimants with musculoskeletal impairments are more likely to be awarded benefits at the initial and ALJ stages than claimants with lower Body Mass Indices (id.).

The final rule therefore should include the language from 1.00Q, which is helpful to adjudicators and can lead to greater uniformity and policy compliance among disability determinations.

Longitudinal Evidence (Proposed 1.00C7 and 101.00C7)

The final rule should not include a requirement that all criteria for a listing must be present simultaneously or "appear in the medical record within a period not to exceed 4 months of one another." When claimants see multiple providers to obtain diagnosis and treatment, have financial or other barriers to seeking consistent care, experience relapsing and remitting symptoms, or simply have providers who make cursory examination notes, symptoms may not occur precisely simultaneously and may not be recorded within a close proximity of time despite occurring within close proximity. When the symptoms, fractures, need for assistive device, or other occurrences that demonstrate that the claimant meets the criteria occurred matters; when they were recorded should not. The final rule should allow providers to opine as to whether listing criteria occurred within a close proximity of time regardless of whether they were recorded in the medical record during a close proximity of time. Moreover, as the Fourth Circuit held in *Radford v. Colvin*, 734 F.3d 288 (4th Cir. 2013), a stringent "proximity-of-findings" requirement is unnecessarily redundant when considering the 12-month durational requirement: "It would be peculiarly redundant to require that a claimant prove that his impairment will last or has lasted at least 12 months and that he produce medical examinations showing that each symptom in Listing 1.04A presents either simultaneously or in sufficiently close proximity such that an ALJ could conclude that the claimant's impairment will last or has lasted at least 12 months." Id. at 293-294.

Proposed Listings 1.15 and 101.15 (disorders of the skeletal spine resulting in compromise of a nerve root(s))

The final listing should make clear that the terms "compromise" or "impingement" of a nerve root are not required to meet the listing. Terms such as "displacement" of the nerve root (such as from a tumor or traumatic injury), "foraminal narrowing," "foraminal stenosis," "neural foraminal stenosis" and "foraminal encroachment" can all indicate compromise of a nerve root; undoubtedly, medical sources use other terms as well.

Where current listings 1.02 and 101.04 require "pain [or] limitation of motion of the spine, [or] motor loss (atrophy with associated muscle weakness or muscle weakness)," the comparable portions of proposed listings 1.15 and 101.15 require muscle weakness AND "signs of nerve root irritation, tension, or compression, consistent with compromise of the affected nerve root" AND at least one of pain, paresthesias, or muscle fatigue. No explanation is given for the increased requirements; nor for the removal of limitation of the motion of the spine. Spinal motion is

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[3] See Page 23, https://www.ssa.gov/OACT/presentations/scgoss_20170726.pdf
[4] See https://www.disabilitypolicyresearch.org/download-media?MediaItemId=%7BCA627EB4-5180-4C77-AD68-1AC81D3B0F63%7D

critical to numerous activities and should not be removed. The final rule should combine 1.15A and 1.15B (and the corresponding sections in the child listings) and allow them to be satisfied when there is at least one of the following neuroanatomically-distributed (radicular) symptoms, accompanied by sensory or reflex loss as described in 1.15B(2) and (3) and the corresponding portions of the child listings: pain; limitation of motion of the spine; muscle weakness or fatigue; signs of nerve root irritation, tension, or compression; and parasthesias.

The final rule should also use plain language such as "pins and needles" along with or instead of the term "paresthesias."

The proposed listings require imaging to confirm nerve root compromise. This is infeasible for many claimants who cannot afford imaging or whose providers do not feel that imaging is necessary in order to treat their conditions. The current rules explicitly state that SSA will not purchase CAT scans, MRIs, or myelograms; the proposed rules cite to regulations that discuss the purchase of x-rays but not other types of imaging and specifically state that myelograms will not be purchased. Therefore, while claimant-submitted imaging could help demonstrate that the listing is met, it should not be a requirement. The final rule should remove 1.15C and 101.15C.

The final rule should also remove 1.15D and 101.15D. Nerve root compromise that meets the criteria of 1.15A and B (edited as discussed above) and the corresponding sections of the child listings can absolutely be disabling even if it does not require the use of an assistive device. An individual whose nerve root compromise causes him or her to experience sensory or reflex loss as well as pain; limitation of motion of the spine; muscle weakness or fatigue; signs of nerve root irritation, tension, or compression; or parasthesias has significant limitations even if he or she can ambulate without an assistive device and can perform fine and gross motor skills with both upper extremities.

Inclusion of 1.15C and 1.15D and the corresponding sections of the child listings would make claimants less likely to meet a listing, and thus require decisionmakers to determine claimants' residual functional capacities, past relevant work and their ability to return to it, and their ability to perform other work in adult claims, and consider functional equivalence across several domains for child claims. Claimants who have sensory or reflex loss as well as pain; limitation of motion of the spine; muscle weakness or fatigue; signs of nerve root irritation, tension, or compression; or parasthesias are likely to be found disabled after the listing step of the sequential evaluation process, but requiring adjudicators to carry out these additional steps will increase the time it takes claimants to obtain disability determinations. SSA recently finalized a rule that substantially limits the issues adjudicators must discuss in their disability determinations and reduces articulation requirements for other issues. The stated purpose for reducing the obligations placed on adjudicators was that "the increasing complexity of cases and voluminous files" meant "it is not administratively feasible" for adjudicators to do as much as they did in the past.[5] SSA is also developing a "streamlined" fully favorable decision template to speed the processing of certain cases where the claimant is awarded benefits. It is therefore incongruous for SSA to propose regulatory changes here that will require adjudicators in many cases to proceed past the listing portion of the sequential evaluation process and make multiple additional findings.

[5] 82 Fed. Reg. 5856 (January 27, 2017). https://www.federalregister.gov/d/2017-00455/p-235

Proposed Listings 1.16 and 101.16 (Lumbar spinal stenosis resulting in compromise of the cauda equina)

The final 1.16 and 101.16 should include "pseudoclaudication" as an alternate term for "neurogenic claudication" as is discussed in proposed 1.00G and 101.00G.

As discussed above, when addressing proposed 1.15C and 101.15C, it is not appropriate for listing 1.16 and 101.16 to require imaging, especially imaging that is expensive, potentially dangerous, and not subject to purchase by SSA. Proposed 1.16C and 101.16C should be removed from the final rule.

Neither proposed listing 1.15 nor 1.16 addresses claimants whose spinal arachnoiditis causes severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours. This elimination of 1.04B will, like changes addressed above, require adjudicators to consider such claimants' residual functional capacities and complete steps 4 and 5 of the sequential evaluation process. This is inefficient given that an individual experiencing severe burning or other painful sensations will almost certainly be significantly distracted by these sensations resulting in time off task and substantially reduced productivity. The need for frequent changes in position or posture also rules out the vast majority of jobs. As SSR 96-09p states, "In order to perform a full range of sedentary work, an individual must be able to remain in a seated position for approximately 6 hours of an 8-hour workday, with a morning break, a lunch period, and an afternoon break at approximately 2-hour intervals. [When an individual needs changes of position that] cannot be accommodated by scheduled breaks and a lunch period, the occupational base for a full range of unskilled sedentary work will be eroded." Thus, it is likely that many individuals who meet the criteria of 1.04B would eventually be found disabled, but their disability determinations would be more complex and time-consuming. They are more likely to require testimony from medical and/or vocational experts (SSR 96-09p states that "It may be especially useful in these situations [where a sit-stand option or other frequent postural change are necessary] to consult a vocational resource") and are more subject to adjudicators' subjective perceptions. Eliminating 1.04B is neither fair nor efficient and the final rule should include it.

Proposed Listings 1.19 and 101.19 (pathologic fractures due to any cause)

The final rule should not limit these listings to pathologic fractures. Claimants who otherwise meet this listing and fulfill SSA's other criteria for disability benefits have equivalent functional limitations whether their fracture resulted from a diagnosed pathological condition that weakens the bones, or whether there was a different or unknown cause for the multiple fractures. Proposed listings 1.22 and 1.23 for complex or non-healing fractures and their childhood counterparts are not sufficient replacements for non-pathologic fractures because they exclude fractures of bones including the skull, ribs, and clavicle.

The final 1.19 and 101.19 should end after the phrase "at least 12 months." The need for a two-handed assistive device, a one-handed assistive device with impairment to the other upper extremity, or limitations to both upper extremities meaning that "neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross

movements" are not necessary functional limitations appropriate to a finding of disability. Claimants who endure three or more fractures at different times in a 12-month period and have resulting musculoskeletal impairments lasting at least 12 months are extremely likely to be found disabled at later stages of the sequential evaluation process; that is why the current listings allow such claimants to be found disabled at step 3 of the process. Such adult claimants will miss work without notice (because fractures are generally sudden and unplanned), require follow-up treatment, be in pain and/or take pain medication that causes distraction and time off task, and experience a variety of exertional and nonexertional limitations that substantially reduce what work is possible. Child claimants will likely have distracting levels of pain, decreased physical function as a result of the fractures and their treatments, and have other effects that result in marked or extreme limitations in the required number of domains. Forcing adjudicators to proceed past the listings when considering such claims will result in decisions taking longer, require the agency to hire medical and vocational experts in more claims, and send more claims to the ALJ level rather than having them adjudicated at the state agency.

<u>Proposed Listings 1.20 and 101.20 (amputation due to any cause)</u>

Proposed 1.20A and 1.20C and their childhood counterparts should have "at or" inserted before "above the wrists." An amputation at the wrist causes essentially identical functional limitations to one just above the wrist. Allowing amputations at, as well as above, the wrists to satisfy this listing matches current listings 1.05 and 101.05, which discuss amputation of "hands." As current 1.00B2b explains, "the individual has the use of only one upper extremity due to amputation of a hand." Making the criteria for upper extremity amputations "at or above the wrist" would also give parity with the proposed criteria for lower extremity amputations, which are "at or above the ankle (tarsal joint)."

Proposed 1.20C1 and its childhood counterpart should remove the words "one-handed" before "assistive device requiring the use of the other upper extremity." An individual who otherwise meets the listing criteria but uses a two-handed assistive device (such as a walker pushed with the residual limb and the other upper extremity, or crutches manipulated on one side by a prosthesis and on the other by the upper extremity) has limitations at least as significant as someone who uses a one-handed assistive device.

<u>Proposed Listings 1.23 and 101.23 (nonhealing or complex fracture of an upper extremity)</u>

Proposed 1.23C and 101.23C should be omitted from the final rule. They are flawed because they fail to distinguish whether the dominant or non-dominant upper extremity is injured, which is a crucial distinction in terms of functional abilities and limitations. More importantly, by requiring claimants to need a one-handed assistive device or have an impairment that impedes the ability to "independently initiate, sustain, and complete work-related activities involving fine and gross movements" in the other upper extremity, in addition to the impairment of the upper extremity in question, the new proposed listing becomes substantially more difficult to meet or equal than the current listing, and SSA provides no basis for the change.

There is no indication that an adult claimant with a complex or unhealing fracture, under continuing surgical management, causing a limitation in musculoskeletal functioning that has

lasted or is expected to last at least 12 months, would be able to perform substantial gainful activity. Similarly, such child claimants would likely have marked or extreme limitations in the required number of domains. This is because such individuals would, by definition, need surgery, likely requiring time away from school or work, with additional time away for preparation and recovery from surgery. As indicated in the NPRM regarding proposed listing 1.21, SSA has a "long-standing recognition that extensive, prolonged treatment in order to re-establish or improve function of the affected body part(s) may contribute to an inability to perform work-related activity." The treatment required for the type of fracture contemplated in proposed listings 1.23 and 101.23 are themselves likely to be disabling.

In addition, individuals with a complex or unhealing fracture, under continuing surgical management, causing a limitation in musculoskeletal functioning that has lasted or is expected to last at least 12 months would also, by definition, have exertional limitations related to lifting, carrying, reaching, handling, fingering, or other motions with at least one upper extremity. Even sedentary work requires these motions to some extent. Such an individual is also very likely to have time off task caused by the distracting effects of pain, side effects from any pain medication, and other exertional and non-exertional limitations (restricted range of motion in the neck or back while wearing a sling, need to avoid situations where the fractured extremity could suffer additional injury, need to avoid water while wearing a cast, etc.). Such individuals are extremely likely to be found disabled after step 3 of the sequential evaluation process, which is why the current listings allow such claimants to be found disabled at step 3. Requiring adjudicators to perform additional steps to award benefits—steps that in many cases will require the testimony of medical and/or vocational experts—is inefficient and will result in more claims appealed to ALJs because a state agency could not or did not award them at the initial or reconsideration level. Maintaining the language of current listing 1.07 and its childhood counterpart would be more appropriate.

Thank you for the opportunity to comment on these proposed regulations.

Respectfully submitted,

Barbara Silverstone
Executive Director