

NATIONAL ORGANIZATION OF  
SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES  
(NOSSCR)

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*Executive Director*  
Barbara Silverstone

November 1, 2016

Carolyn Colvin  
Acting Commissioner  
Social Security Administration  
6401 Security Boulevard  
Baltimore, MD 21235-6401

**Submitted on [www.regulations.gov](http://www.regulations.gov)**

Re: Notice of Proposed Rulemaking on Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. 62559 (September 9, 2016), Docket No. SSA-2012-0035

Dear Acting Commissioner Colvin:

These comments are submitted on behalf of the National Organization of Social Security Claimants' Representatives (NOSSCR). 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. Since 1979, NOSSCR has been providing continuing legal education to its thousands of members, and public policy advocacy on behalf of its members and the people with disabilities they represent. 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.

Thank you for the opportunity to comment on the proposed regulations contained in this Notice of Proposed Rulemaking (NPRM). While NOSSCR generally supports SSA's efforts to keep its rules current with changes in the national healthcare workforce, simplify and reorganize its rules for ease of use, and allow SSA to continue to make accurate and consistent decisions, these proposed rules will not accomplish those goals. NOSSCR objects to many aspects of the

proposed rules regarding the evaluation of medical evidence and urges SSA not to move forward with finalizing these regulations. NOSSCR's general objections are as follows:

- These rules will not lead to more accurate decisions or decrease processing time. If anything, they will lead to more appeals, more remands, and more delays. The process of training adjudicators on this complex new regulation and adapting SSA systems to comply with it will be difficult, time-consuming, and expensive.
- SSA should continue requiring disability determinations to provide the rationale for how the decision was made. The provisions in this proposed rule that remove the responsibility of adjudicators to explain how they weigh certain evidence and prior administrative decisions, for example, is likely to increase appeals and court remands rather than decrease them. Courts will not be able to determine whether "substantial evidence" supports SSA's decision unless adjudicators adequately explain how they arrived at their decisions.
- Some of the provisions contained in this NPRM conflict with the Social Security Act.
- Some of the changes proposed in this NPRM are not evidence based and do not rely on current data. For example, to our knowledge, SSA has not attempted a test in which it adjudicates a sample of claims under the current and proposed rule and compares the speed and accuracy of determinations under each set of policies.

NOSSCR urges SSA not to move forward with or to alter many of the provisions contained in this NPRM. Specifically:

- **Acceptable Medical Sources (20 CFR §404.1502(a) and §416.902(a)):** NOSSCR strongly supports SSA's proposal to add audiologists and licensed advance practice registered nurses (APRNs) to the list of "acceptable medical sources." However, NOSSCR urges for more expansion, including physician assistants (PAs), licensed clinical social workers (LCSWs), chiropractors, and physical therapists, based on the reality of who in the current healthcare workforce provides treatment.
- **Decisions by other governmental agencies and nongovernmental entities (20 CFR § 404.1504 and § 416.920b):** NOSSCR opposes SSA's proposed revisions to how decisions by other governmental agencies and nongovernmental entities are considered. SSA should continue to require adjudicators to articulate whether and to what extent medical opinions and prior administrative medical findings are considered.
- **How SSA Considers Evidence (20 CFR § 404.1520c and §416.920c):** Many changes in the NPRM are premised on the idea that individuals no longer have long-standing or strong relationships with treating sources. NOSSCR disagrees with that premise. Many disability claimants and beneficiaries have important relationships with their treating providers. As SSA recognizes when proposing expanding "acceptable medical sources," treating sources are not (and truly never were) all physicians. NOSSCR supports the current rule, which requires adjudicators to give treating source opinions from acceptable medical sources controlling weight in most circumstances; when such opinions are not given controlling weight, the adjudicator must explain why not. NOSSCR also supports giving *additional* weight to opinions from acceptable medical sources than from those who perform a single examination or a review of a paper file, even in situations where *controlling* weight may not be appropriate. The inability of some SSA adjudicators to

adequately explain how they weighed conflicting evidence does not justify treating all evidence equally, but rather argues for better training and supervision of adjudicators.

NOSSCR urges SSA to withdraw the proposals to eliminate the treating source rule and to no longer give controlling weight, or any special consideration, to evidence received from a treating acceptable medical source. It is NOSSCR's position that the relationship a claimant has with a treating source means treating source opinions deserve more weight than the opinions of an individual who performs a single examination or reviews a claimant's paper file. Should SSA move forward with eliminating controlling weight for treating sources, NOSSCR urges that the agency retain the rest of the current framework for giving treating sources additional weight and adopt the suggestions contained in these comments. NOSSCR fully supports expanding the list of acceptable medical sources, but urges SSA to go further than proposed and include additional treating sources as acceptable. Our specific comments to the proposed rules appear below.

#### **I. Definition of "Acceptable Medical Source" (20 CFR §404.1502(a) and §416.902(a))**

NOSSCR fully supports SSA's proposal to add audiologists and APRNs to the list of acceptable medical sources. We further support expanding the list to include physician assistants (PAs) and licensed clinical social workers (LCSWs). The licensing, education, and training requirements for PAs are sufficient and consistent nationwide. Per the American Academy of Physician Assistants (AAPA), for initial licensure of PAs, all states require, at a minimum, graduation from an accredited PA program and passage of the Physician Assistant National Certifying Exam (PANCE), which is administered by the National Commission on Certification of Physician Assistants (NCCPA).<sup>1</sup>

Likewise, for LCSWs, all states have a minimum educational requirement of a Master of Social Work degree and require passage of one of four of the exams offered by the Association of Social Work Boards (ASWB), typically the clinical exam.<sup>2</sup> Similar to APRNs, supervised post-degree experience is an additional requirement for LCSWs in most states, ranging from 3,000 hours to 24 months.<sup>3</sup> In addition, a substantial number of people with mental health conditions and psychiatric disabilities have LCSWs as their primary mental health care providers. The National Association of Social Workers estimates that 60% of mental health professionals are clinical social workers, compared to 10% who are psychiatrists, 23% who are psychologists, and 5% who are nurses.<sup>4</sup> An LCSW is often the provider best able to offer an informed and detailed opinion about the mental health of a Social Security disability claimant or beneficiary. Therefore, NOSSCR supports the addition of audiologists and APRNs to the list of acceptable medical sources, and would support adding both PAs and LCSWs to this list.

NOSSCR recommends the final rule specifically state that Nurse Practitioners are acceptable medical sources. This will avoid confusion. There are numerous examples of nurse practitioners

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<sup>1</sup> <https://www.aapa.org/become-a-pa/>.

<sup>2</sup> <http://aswbsocialworkregulations.org/jurisdictionLevelsReport.jsp>.

<sup>3</sup> *Id.*

<sup>4</sup> <https://www.socialworkers.org/pressroom/features/issue/mental.asp>.

being the primary treating source for patients<sup>5</sup> and specifically naming them in the category of APRN would clarify their role.

We appreciate SSA's willingness to add other medical professionals to the list of acceptable medical sources. This recognizes the fact that many patients today are treated by other professionals in addition to, or instead of, MDs—either by choice or necessity.

NOSSCR recommends that SSA also include chiropractors and physical therapists as acceptable medical sources within the specific scope of practice requirement. Doing so not only recognizes the way many people receive medical care today, but would also create a uniform rule and reduce the number of cases filed in federal courts, which are ultimately remanded due to the ALJ's failure to give proper consideration to medical evidence provided by these sources. Including them specifically in the list of acceptable medical sources would clarify the rule. These medical professionals are also subject to strict education and licensing requirements. For example, in *Santiago v. Bowen*, 715 F.Supp.614 (S.D.N.Y. 1989) the court noted the rigorous four-year training of chiropractors, which is the same length as medical school, and the licensing requirements in the state of New York. In *Barrett v. Barnhart*, 355 F.3d 1065 (7<sup>th</sup> Cir. 2004), the court recognized that patients are more likely to seek relief from chronic problems from a physical therapist than an orthopedist. Properly trained physical therapists can provide personalized treatment and often have ongoing treatment relationship with their patients.

## **II. Decisions by other governmental agencies and nongovernmental entities (20 CFR § 404.1504 and 20 CFR § 416.920b)**

The NPRM, if finalized, would allow SSA adjudicators to not provide any analysis in their disability and blindness determinations about how they considered decisions made by other governmental agencies or nongovernmental entities that an individual is disabled, blind, or unemployable. The proposed rule would also clarify that SSA is not bound by these other agencies' and entities' decisions.

NOSSCR opposes the proposal to rescind Social Security Ruling (SSR) 06-03p and change how disability decisions from other governmental agencies and nongovernmental entities ("other agencies") are considered. We believe that SSR 06-03p was correct when it said "These decisions, and the evidence used to make these decisions, may provide insight into the individual's mental and physical impairment(s)" (emphasis added); the decisions themselves, and not just the evidence used to make the decisions, have value. NOSSCR recognizes that other agencies have different standards for determining disability and agree that SSA need not be bound by other agencies' determinations, but we believe SSA adjudicators should, as SSR 06-

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<sup>5</sup> See, e.g., *Voigt v. Colvin*, 781 F.3d 871 (7th Cir. 2015); *Shontos v. Barnhart*, 328 F.3d 418 (8<sup>th</sup> Cir. 2003): Nurse practitioners and therapists are "other medical sources" whose opinions are considered medical opinions, pursuant to 20 §§CFR 404.1527(a)(2) and 404.1513(d)(1). Although some courts have found that nurse practitioners are only acceptable medical sources under the current regulations if they work under the supervision of physicians, SSA could and should make regulations that consider nurse practitioners to be acceptable medical sources when they work independently as well. This would reflect the nature of some claimants' treatment and not penalize claimants for the diverse working environments of the medical professionals who know them best.

03p currently requires, “explain the consideration given to these decisions in the notice of decision for hearing cases and in the case record for initial and reconsideration cases.” This is in keeping with the Social Security Act, which requires the agency to make determinations “on the basis of evidence adduced at the hearing.” Allowing adjudicators to ignore this specific class of evidence does not comport with the Social Security Act.

It is not accurate to say, as does the preamble to the proposed rule, that “other governmental agencies' or nongovernmental entities' decisions give us little indication whether a claimant is more or less likely to be found disabled or blind under the Act.” Although the probative value of other agencies' or entities' decisions will obviously vary, SSA's own research shows that veterans with 100% disability ratings or an IU ratings are substantially more likely to be found disabled than the general population of SSDI applicants.<sup>6</sup>

NOSSCR continues to support SSA's current policy of expediting claims for those classified as “military casualty/wounded warriors” and for veterans with 100% permanent and total disability compensation ratings from the VA. Given that veterans with 100% disability compensation ratings have a high award rate for Social Security disability benefits when they do apply,<sup>7</sup> we urge SSA to continue considering VA disability ratings and other agency decisions when making disability determinations and not just in determining the order in which claims are processed.

NOSSCR agrees that some claimants' files may not have complete information about the reasons underlying another agency's determination. But some files do contain this information, and we disagree with the proposed rule, which would release adjudicators from the need to consider it when it does appear. In addition, another agency's disability determination may include other information that may be important for assessing medical and non-medical criteria for Social Security disability benefits. Such a determination could include information about a claimant's income, work history, marital status, or immigration status. It could include an adjudicator's observations of the claimant or information about the medical treatment a claimant receives. Modifying 20 CFR §§404.1504 and 416.904 to state that SSA “will not provide any analysis in our determinations and decisions about how we consider decisions made by other governmental agencies or nongovernmental entities” means that claimants and their representatives will have no way of knowing whether the SSA adjudicator reviewed the evidence at all, or whether the adjudicator gleaned these or other important pieces of information from the determination. The proposed rule does not forbid consideration of other agencies' determinations, so it is possible that an SSA adjudicator would consider another agency's determination but not state that they did so. An adjudicator could, conversely, fail to consider another agency's determination and never explain why. It will be impossible to know, therefore, whether the adjudicator's decision was based on substantial evidence. This change would take SSA decisions further away from the standards articulated in numerous federal court cases, including the Ninth and Fourth Circuit cases cited in footnote 42 of the NPRM. These cases require the agency to provide great or substantial weight to VA determinations, absent reasoned and fact-specific explanations. Changing the rules so that adjudicators are not required to give any weight to VA determinations and never have to explain their reasoning on this topic would therefore lead to more appeals and probably more remands.

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<sup>6</sup> See <https://www.ssa.gov/policy/docs/ssb/v74n3/v74n3p1.html> Chart 16.

<sup>7</sup> See *id.* at Chart 4.

A better approach than the one proposed in the NPRM would be to provide additional training and more quality reviews of adjudicators' decisions. Helping DDS examiners and Administrative Law Judges (ALJs) to articulate how they weighed these decisions is consistent with the jurisprudence in cases where other agencies' decisions were at issue. NOSSCR urges SSA to preserve SSR 06-03p, withdraw this regulatory proposal, increase the training provided to adjudicators regarding articulating how other agencies' or entities' decisions were weighed, and conduct more quality reviews of written decisions to identify training needs.

### **III. How we consider and articulate medical opinions and prior administrative medical findings. (20 CFR § 404.1520c and 20 CFR §416.920c)**

NOSSCR strongly opposes the changes proposed in this section. NOSSCR supports the current rule, which requires adjudicators to give treating source opinions from acceptable medical sources controlling weight in most circumstances; when such opinions are not given controlling weight, the adjudicator must explain why not. NOSSCR urges SSA not to change these rules. The reasons provided in the preamble to the proposed rule are not compelling. It is NOSSCR's position that the proposed changes will reduce accuracy of decisions and will undermine the legitimacy of decisions by making them significantly less transparent. This proposed rule would give adjudicators excessive discretion with little direction as to how it should be applied. SSA's current rules on the topic are clearer, and the treating physician rule already has safeguards in place to ensure that the only medical opinions given controlling weight are those that are consistent and well-supported by the record. As such, NOSSCR urges SSA to refrain from adopting this proposed rule.

#### **A. The Proposed Changes Are Inconsistent with the Social Security Act**

As the Supreme Court noted in *Black and Decker v. Nord*, 538 U.S.822, (2003) (*Black & Decker*) "The treating physician rule at issue here was originally developed by Courts of Appeals..."<sup>8</sup> based on the requirements in the Social Security Act itself. SSA cannot eliminate the need to give more weight to treating sources than to non-treating sources through the regulatory process, because courts will likely continue to impose a treating physician rule of some kind, as they did before SSA introduced its 1991 regulations. The Act's specific requirement that "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"<sup>9</sup> implies that Congress recognized special knowledge that a treating source can provide regarding a claimant's impairments and the inherent value in this medical evidence. This section indicates that special consideration should be given to the opinion of a treating physician or other treating health care provider. Prior to the 1991 regulatory scheme enacted to codify the treating physician rule, courts certainly interpreted it that way. It is likely that courts will respond to a regulatory

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<sup>8</sup> 538 U.S. 822, 828 (2003).

<sup>9</sup> Section 223; 42 USC 423(d)(5)(B).

change that places treating sources on equal footing with non-treating sources the same way they did before 1991.

SSA's reliance on *Black and Decker*) in the NPRM is misplaced and does not support an elimination of the entire evidence evaluation framework currently in place. Neither does the Administrative Conference of the United States (ACUS) report SSA commissioned in 2013.<sup>10</sup> ACUS, when reviewing SSA's treating physician rule, relied on a phrase in *Black & Decker*: "And if a consultant engaged by a plan may have an 'incentive' to make a finding of 'not disabled,' so a treating physician, in a close case, may favor a finding of 'disabled.'" In the preamble to the NPRM, SSA interpreted this statement to mean that treating sources are more likely to find that the claimant is disabled. But this is not what the Supreme Court meant. In *Black & Decker*, the Court made a comparison: if doctors paid by benefit plans might lean towards finding a claimant not to be disabled, it would follow that treating doctors might be more inclined to find a patient is disabled. But the Court does not say anything about a "built-in evidentiary bias." Instead, the Court simply held that SSA's treating physician rule is not applicable in ERISA cases. The Court reasoned that SSA has regulations which govern the weight to be applied to a treating physician's opinion in a Social Security disability claim. But because no similar Department of Labor regulations exist, and because the ERISA statute itself does not contain any reference to evidence from a treating source (in contrast to the Social Security Act), the Supreme Court held that the courts cannot require application of a treating physician rule to employee benefit claims made under ERISA. *Black & Decker* should not be read to conclude that treating physicians cannot issue unbiased medical opinions regarding their patients, nor that the current regulatory provisions creating the additional weight given to treating sources is inappropriate or needs to be changed.

### **B. Increasing Complexity of Cases and Size of Files Do Not Justify Changing the Regulatory Framework for Evaluation of Evidence**

One reason put forth by SSA for eliminating the current treating source rule is that some claims files are too large for adjudicators to properly consider all of the evidence.<sup>11</sup> SSA also asserts that people now see more specialists and often submit evidence from a variety of sources, making it harder for adjudicators to apply the treating source rule. NOSSCR recommends that SSA instruct its adjudicators on how to weigh opinions from multiple treating sources instead of eliminating the rule altogether. If the current rule no longer reflects current treatment scenarios, it should be revised to account for the current situation of managed care and multiple treating sources (including but not limited to physicians), while still granting controlling weight to the opinion of a long-time treating source or primary care provider. People may have multiple providers because they have multiple impairments. It is possible to create a rule that allows adjudicators to give opinions more weight when they are evaluating the impairment for which a provider provided treatment.

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<sup>10</sup> Administrative Conference of the United States, SSA DISABILITY BENEFITS PROGRAMS: ASSESSING THE EFFICACY OF THE TREATING PHYSICIAN RULE, Final Report: April 3, 2013, [https://www.acus.gov/sites/default/files/documents/Treating\\_Physician\\_Rule\\_Final\\_Report\\_4-3-2013\\_0.pdf](https://www.acus.gov/sites/default/files/documents/Treating_Physician_Rule_Final_Report_4-3-2013_0.pdf)

<sup>11</sup> "Due to voluminous case records in some cases, it is not always administratively feasible for us to articulate how we considered each of the factors for all the medical opinions and prior administrative medical findings in a claim while still offering timely customer service to our claimants."

Assessing numerous, at times conflicting, statements and evaluating the probative nature of each in accordance with laws and regulations is the very job of an adjudicator. The fact that adjudicators are tasked with making many findings is not a reason to change the weight given to evidence. In addition, the proposed framework would not simplify this task; it would give less guidance and more discretion to adjudicators on how to weigh evidence. It would then remove the requirement that the adjudicator articulate how he or she did so, unless the adjudicator has to assess the persuasiveness of the evidence.

The issue of “voluminous case files” cannot be allowed to reduce adjudicators’ responsibilities or the due process given to claimants. The proposed rule could amount to a denial of a claimant’s right to have his or her case decided on the totality of the evidence and a violation of the adjudicator’s long-standing duty to make a decision based on all of the evidence in the record.<sup>12</sup> Case files are longer for many reasons, including SSA’s all evidence rule,<sup>13</sup> long processing times, and the repetitive nature of electronic medical records. People with long claims files are no less likely to be disabled, and no less deserving of due process, than people with short claims files. NOSSCR again notes that adjudicators are required to make a decision based on all of the evidence in the record. If there is too much evidence, then SSA might consider revising the recently enacted rules requiring submission of all evidence and reduce hearing-level processing times. These have resulted in voluminous files. Allowing adjudicators to disregard relevant evidence, or no longer requiring them to articulate how they considered that evidence, are not acceptable solutions.

Instead of removing the articulation requirements, SSA should give adjudicators and their support staff the training and support they need to do their important work properly. Removing adjudicators’ responsibility to “show their work” will not reduce appeals and remands. A federal judiciary that currently remands many cases to the Commissioner due to articulation errors is unlikely to be more deferential to an agency that simply stops articulating at all. In fact, the courts might even find these regulations to be impermissible. The Commissioner cannot, by regulation, remove adjudicators’ statutory duty to consider the entire medical record and articulate how a decision is reached.

### **C. Treating Source Relationships Still Exist and Should Be Afforded Additional Weight**

As mentioned above, NOSSCR disputes the assertion that the nature of healthcare has changed to the point that treating source no longer deserve additional more weight. Although it is true, in certain cases, that some people no longer have a primary care physician, many people who have chronic conditions and disabilities have ongoing relationships with some type of healthcare provider. Those providers might be APRNs, PAs, LSCWs, physical therapists, or audiologists

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<sup>12</sup> “An ALJ has a duty to ensure that the administrative record is fully and fairly developed.” See 20 CFR 404.1512(d)-(e) and 416.912(d)-(e). See also, *Lucas v. Sullivan*, 918 F.2d 1567 (11<sup>th</sup> Cir. 1990); *Way v. Astrue*, 789 F.Supp.2d 652 (D.S.C. 2011); *Scott v. Shalala*, 898 F.Supp.1328 (N.D. Ill. 1995).

<sup>13</sup> 20 CFR §§404.1512(a) and 416.912(a).



(just to name a few) rather than doctors, but the treating relationship is still important and still deserves the value placed on it by the existing treating source rules.

The 2013 ACUS report cites several studies indicating some people change their primary care providers due to insurance changes or personal preference, but those studies actually showed that many people keep their providers for long periods of time—certainly long enough to establish a relationship exceeding what one might encounter in a consultative examination or file review.<sup>14</sup> It is also possible that as the Affordable Care Act allows more people to obtain medical insurance and carry it with them between jobs, and as more Baby Boomers qualify for Medicare (with several years in which they might apply for or receive SSDI, due to the increase in the full retirement age), some people are experiencing more consistent medical treatment than they did in the past. Although the way some patients receive medical care has changed since the current rules were issued in 1991, if a patient does have a long-standing relationship with a long-time treating source, the opinion of such a medical source should continue to be given its current weight. The ACUS report does not deny the importance of a long-standing treating source/patient relationship when one does exist.

The relationship between an individual and their treating provider is special and the opinions of treating providers deserve more weight than the opinion of someone who either examines an individual once or only reviews the claims file. The evidence from a treating source is generally more persuasive because treating providers *treat*. A provider would not prescribe medication, recommend tests, give advice, refer to a specialist, perform surgery, or provide other treatments unless they found the patient's reports and their own observations and conclusions persuasive enough to require these actions.

In 1991, SSA stated that a treating source opinion “tends to have a special, intrinsic value because treating sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of a claimant's medical history and may bring a unique perspective to the medical evidence.”<sup>15</sup> SSA fails to make the case in this proposed rule that what it said in 1991 is no longer true. Many insurance companies today require that patients receive a referral from their primary care physician. This physician, often the “gatekeeper” and coordinator of the various treatments that a patient receives from specialists, can provide an opinion based on medical evidence from several treating specialists.

It is NOSSCR's position that when a treating or primary care source relationship does exist, the current rules continue to be appropriate. Furthermore, it should be possible for SSA to give controlling weight to one provider for one impairment and another provider for another

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<sup>14</sup> ACUS, *supra* note 10, at fn.221. For example, the ACUS paper describes a 2003 study by Paul Nutting et al. as “summarizing studies showing that only about 50% of surveyed patients reported continuity of regular physician,” but Nutting's study itself states that “In the practice settings examined in this report, more than 90% of patients saw their regular physician. In these family practices it appears that patients were able to achieve continuity for many of those visits in which it is hypothesized to be important.”

[http://www.hpm.org/Downloads/Bellagio/Articles/Continuity/Nutting\\_et\\_al\\_2003\\_3ItemsMeasure\\_Continuity.pdf](http://www.hpm.org/Downloads/Bellagio/Articles/Continuity/Nutting_et_al_2003_3ItemsMeasure_Continuity.pdf)  
The ACUS paper also cites a 2000 study where 24% of the surveyed population had been forced to change family doctors in the previous three years due to insurance change; this indicates that the vast majority were able to maintain their primary care providers for at least three years.

<sup>15</sup> 56 Fed. Reg. at 36934 and 36961.

impairment, or to reconcile opinions that differ or conflict. Assessing multiple pieces of evidence, reconciling inconsistencies, and arriving at a policy-compliant decision is precisely the job of an adjudicator.

#### **D. Treating Source Opinions Should Still Receive Additional Weight Even if Not Controlling Weight**

NOSSCR strongly urges SSA to retain the current framework giving treating source opinions controlling weight when supported and consistent. If the agency chooses not to, NOSSCR urges SSA to maintain the rest of the framework for giving treating sources more weight than non-treating medical sources. SSA fails to provide a compelling rationale that treating source opinions should be placed on an even level with those of someone who completes a consultative examination (CE) or a file review, as the proposed rules would do. Even if a treating relationship is short, it is still longer than a CE or a file review.

SSA fails to explain why the factors adjudicators must currently use to determine what weight to give opinion evidence need to be altered, or why the order in which the factors are applied should be changed. The first factors to be examined should continue to be whether the source has examined the claimant and the nature and length of the treatment relationship, followed by whether the opinions are supported and consistent.<sup>16</sup> NOSSCR supports continuing to include whether or not the treating source is a specialist as a factor in determining whether to give controlling or additional weight to a treating source.

However, NOSSCR strongly opposes two factors the NPRM would use to evaluate the persuasiveness of evidence: familiarity with SSA rules and having completed a review of the entire file. These factors tip the scale toward MC and CE opinions and SSA does not provide a compelling rationale for including these factors. These two factors reflect the role of the adjudicator – being familiar with SSA rules and reviewing the entire file – and not the role of a medical source, especially because knowledge of SSA’s policies is generally not required except to make a determination that is reserved for the Commissioner.

SSA fails to provide any convincing reasons as to why being able to review the whole file and knowing SSA’s policies should be considered on an equal level to the other factors. To the contrary, the opinion of a specialist who has an ongoing relationship with the claimant, on a condition within the specialist’s area of expertise, is likely to be more accurate than the opinion of a generalist who knows SSA’s policies and reviewed the whole file in regard to that particular impairment. In addition, SSA’s proposed rules provide no explanation of the relative importance of the factors. Does SSA envision that reviewing the whole file is as important as whether the source examined the claimant? The proposed rule is less clear than the current rules and may result in more appeals and remands.

Some opinions are written down long before a case file even exists but that does not make them less persuasive. At the same time, when a MC reviews a file at the initial level, given the extremely long delays waiting for hearings, it is likely that the individual’s conditions have

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<sup>16</sup> See 20 CFR §404.1527(a)

changed and significantly more evidence is in the file. The MC reviewed the entire file at the time of the initial decision, but not the entire file by the time an ALJ makes a decision. As written, an ALJ could find the MC opinion more persuasive, even though the MC reviewed a record lacking material evidence available at the time of the appeal.

Although NOSSCR strongly opposes any dilution of the current treating physician rule, should the proposed rule be adopted, we disagree with the concept that, in place of a long standing treatment relationship, supportability and consistency will be the most important factors to consider when evaluating the evidentiary value of medical opinions and prior administrative medical findings. The treatment relationship and specialization (when appropriate) are more important factors, as they are under the current framework.

#### **IV. Other Proposed Changes**

##### **A. Your Medical Source (20 CFR §404.1519h, i and 20 CFR § 416.919h, i)**

NOSSCR supports SSA's proposal stating that the preference for consultative examinations will be any of a claimant's medical sources. We also support SSA's proposal to use the existing standard to decide whether to select the claimants' medical source for the consultative examination.

##### **B. How We Consider Evidence (20 CFR §404.1520b and §416.920b)**

NOSSCR opposes proposed 20 CFR §§404.1520b and 416.920b that would replace the word "weigh" with "consider". Although SSA's stated reason for changing the language is to avoid confusion when "weigh" is used in many places, in fact these two words have different meanings. While "consider" means simply to think about, "weigh" means to assess the importance of a piece of evidence in relation to other evidence. Therefore, this proposed change in language would, in effect, allow adjudicators simply to think about the evidence rather than determine which evidence is more persuasive or important.

##### **C. Statements on Issues Reserved to the Commissioner (20 CFR 404.1520b(c)(3) and 416.920b(c)(3))**

If SSA issues a final rule on this topic, we urge it to include a statement explaining that evidence including statements on issues reserved to the Commissioner should not be completely disregarded. Instead, the statements on issues reserved to the Commissioner should be given their appropriate weight, and other statements, findings, or opinions should be given their appropriate weight.

We also urge SSA to clarify that merely using terms that appear in listings, domains, the medical-vocational grids, or elsewhere in SSA's law and regulations does not indicate that a statement is on issues reserved to the Commissioner. Words like "moderate," "marked," "sedentary," and other terms are frequently used by medical providers and others. An adjudicator

need not be bound to others' conclusions on issues reserved to the Commissioner. But adjudicators should be cautioned not to ignore statements that are on issues not reserved to the Commissioner just because they use words that appear in SSA's own laws and policies. As an example, "Mrs. Smith is restricted to sedentary work" is a statement on issues reserved to the Commissioner, but "Mr. Jones has led a more sedentary lifestyle since his accident and can no longer climb stairs or stand without a cane" is not.

### **Conclusion**

NOSSCR urges SSA to withdraw most of this NPRM and to only move forward with the expansion of acceptable medical sources. We urge the agency to further expand the list with the inclusion of PAs and LCSWs, as well as chiropractors and physical therapists. NOSSCR strongly opposes the proposed changes to the way SSA will consider decisions by other governmental agencies and entities, and the changes SSA proposes to make to how evidence from treating and non-treating sources will be evaluated.

SSA also proposed to rescind the following SSRs: 96-2p, 96-5p, and 96-6p. Because NOSSCR opposes the changes in the regulations that would render these rulings inconsistent, and because NOSSCR finds that these Rulings provide adequate explanation of the rules on evaluating and weighing medical evidence, NOSSCR opposes the rescission of these rulings.

NOSSCR emphatically supports maintaining the current rule recognizing the "intrinsic value" of the treating source/-patient relationship and urges SSA to continue to afford such opinions controlling weight when the requirements for consistency and supportability are met. Should SSA choose to move forward with eliminating the controlling weight aspect of the way it currently evaluates evidence from treating sources, NOSSCR urges SSA to maintain the rest of the current regulatory framework for giving treating sources additional weight over non-treating sources based on the nature and the length of the treating relationship.

Thank you for considering these comments.

Sincerely,

Barbara Silverstone  
Executive Director