

COMMENTARY
ON THE
DRAFT REPORT
ON IMPROVEMENT OF
SOCIAL SECURITY DISABILITY
EVALUATIONS

Report

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Of Chicago-Kent College of Law for Review by the

Adjudication Committee of ACUS

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This comment is based on my own opinions and not reflective of any organization or firm membership or affiliation.

SUMMARY: This Report attempts to deal with “Attending & Treating Physician” rule as adopted by Social Security. The conclusion seems to be that the rule creates more problems than solutions and has resulted in conflicting decisions that suggest need for a change by SSA. The legal and factual basis is flawed and fails to take a changed reality into consideration.

NOTE: ACUS was reborn after a short hiatus in Limbo. ACUS endangers its future if budget cuts need to rethink this rebirth as a worthwhile effort. The concept of ACUS is valid, but only if productive and fruitful debate on improvement of the administrative systems established by Congress leads to results. I doubt if this Report will make that grade.

ADMONITION: Read the footnotes or your children will starve.

- A. p. 1. “Indeed, of the bases for remand by federal courts that are tracked by SSA, the treating physician rule-based remands are the highest category of remands. fn6”

fn 6 “Treating physician rule-related remands are a subcategory of the Opinion Evidence Evaluation & Residual Functional Capacity (“OEE & RFC”) classification and represent the percentage of remand frequency within that classification. The OEE & RFC classification is itself the most frequently cited remand category. See id at A-3 tbl.2.

The Table (p.A-3) outlines the reasons for remands from Courts during the time 2009-2011 FY. Of the 10 reasons (“not mutually exclusive”) listed, OEE & RFC topped the category at 54%. Other double digit reasons are “2. Severe/Non-Severe 15%; Credibility Evaluation 19%; Grid/Vocational Expert (sic GRID) 16%; Miscellaneous 21%

COMMENT: OEEs can be inserted in the process at two different stages. State Agencies make the initial two decisions on a disability claim. Federal Regional Offices will pull some sample decisions and send to Quality Review Branches to make sure the medical portion of State decisions are up to snuff by Federal standards. These medical reviews(OEEs) can be found in the file on appeal to an ALJ.

A second OEE can be done at the initial evaluation signed off by contract doctors who confirm the decision of the adjudicator at the State level (SSA-831). This can be expanded to completion of SSA medical forms (other than the RFCA) such as

the Psychological Review Technique Form (PRTF) and Mental Residual Functional Capacity Assessment (MRFCA). These forms are used internally to make an assessment of mental problems on the ability of a person to function (thus involving “Sever/Non-Severe” issues). The RFC form is an 8p assessment by a State agency physician or psychologist that checks off boxes of limitations (or abilities) based on a review of existing medical records in the file. Some ALJs use RFCs as a tool when a medical expert is available at Hearings. Given the limitations posited in hypothetical questions to a Vocational Expert, any “remand” by a Court may base the remand on a bad RFC use by the VE. In short, the 54% remand rate can be questioned as the Big Tuna in the pond. The other fish are involved. Changing the rule on treating physician dominance may not cure the 54%

My own sense for the remand bubble stems from the absence of discussion of why one doctor’s opinion is better or worse than another. The existing pecking order for a bad back case:

1. 3x post Sx Attending ortho surgeon after a year of therapy saying “failed back” and cannot work at any job due to pain with documentation
2. Family doctor (internist) for 10 years who sent the patient to #1 and has reviewed all the medicals and send a 3p letter w/CV attached (Harvard)
3. One time shrink in person assessment with appropriate testing to measure the depth of depression due to the bad back. Rx Antidepressant and counseling with family(LCSW)
4. SSA Orthopod hired by Illinois DDS to review 3x Sx of back, family doctors report and mental health report – disputes prior assessments and backs up with facts and admissions by patient to activities that indicate ability to do sit down, non-stressful jobs
5. SSA outside one time examiner (internist) on contract with the State and without examining entire medical file in a 20 minute “exam”
6. Chiropractor hired by WC attorney to treat and assess back problems
7. Non-treating, non-examining OB/Gyn from State making an assessment without stating which records examined (RFC)
8. A/P seen 3x in 3 years writing “disabled” on a Rx pad.

The State of Illinois cannot afford the best doctors to do the best assessments. The ALJs have the same problem. I don’t know the AC situation.

- B. Dr. Welby is dead. Agree that licensed physicians are not the only ones who have medical opinions that can help provide a basis for deciding someone is

disabled. Nurse Practitioners (NPs), Physician Assistants (Pas) and Licensed Clinical Social Workers (LCSWs).

C. p.4 “In contract to most administrative adjudications, the agency is not represented at the hearing. fn 22

fn 22 “The [VA] is the other most notable example.”...

If “most” is numerical, the statement is not correct. If “most” refers to agencies, it is correct.

Conceptually, SSA is supposed to help any claimant other than the burden of proof. SSA “gets” medical records for the claimant. SSA calls friends and family to document epileptic seizures. SSA sends claimants to their own doctors for free exams if possible. SSA has a great user friendly web site; 1 800 number to call for help; local District Offices in almost all neighborhoods with Claims Representatives (overburdened currently) ready to help.

ALJs wear the traditional Tricorn hat. Be fair to the claimant; be fair to the Fisc; be fair to the Law. SSA tried a sample program of attorney reps at Hearings and dumped it for logistical reasons back in the 80s. In short, the ALJ represents SSA.

D. P.7 “The treating physician rule thus began as a rule ‘developed by Courts of Appeal as a means to control disability determinations by [ALJs] under the Social Security Act’ fn 48”

Fn 48 cites the Black & Decker Disability Plan case decided by the Supreme Court in 2003, p.829. Dictum at best since this was an employer/employee benefits claim governed by contractual terms under ERISA guidelines. Extensive discussion and citations on cases supporting the preference for the opinion of the treating physician absent contrary evidence. (see: p.12, fn 96 for the 5 factors that can upset a treating physician opinion).

NOTE: After 40 years of handling disability claims for thousands of individuals, I have never seen a discussion in an initial determination that indicated why the A/P opinion was disregarded based on specifics. If anything, a generic “We have considered all the medical evidence and have determined...” This is another example of the lack of consistent treatment at different levels of the disability claim process, sometimes labeled as “Singing from the Same Prayer Book”.

Another example? Why does each state DDS have a different form for doctors to complete for a bad back? Are backs in Alabama different from those in Illinois? You want to reduce remands? The only solution would be to federalize the SSA disability system – no guts, no glory, no re-elected.

p. 14 “As a result [of the rule], ALJ decisions have become increasingly vulnerable to challenge.”

I disagree strongly. There is no proof of cause & effect. I can just as easily blame vulnerability on bad decision writing and failure to follow the rule itself. The fact that ALJs are under the gun to “produce” 500 to 700 decisions each year does not help write “good” decisions that withstand AC & Court scrutiny. Recent efforts to bolster the ALJ Corps have resulted in many SSA Attorney Advisors submitting resumes for selection as ALJ in a challenged process by OPM. There is a diminished set of incoming attorneys from the private sector with 6 years of trial experience. I was the ABA rep on the 3 person evaluation committee, along with an ALJ and OPM rep. during the 80s. In-house breeding is happening and the best candidates are not often selected.

p.16. fn 118. Reliance on a statement being supported by 6 9th Circuit Opinions covering 1989 to 2012 does not seem balanced scholarship. Being in the 7th Circuit is much more interesting.

Fn 119. Citing unpublished District Court cases as authority seems way to light for ACUS acceptance.

p.17. Use of the discredited Senate Permanent Subcommittee Investigations Report, even if supportive of changing the rule, is not good.

Credibility and pain have always been a problem that Courts are reluctant to second guess over an ALJ well rounded decision. Polaski (1984) controls. The presumption that a claimant under oath is not lying can be overcome with some questioning about the six “factors” (Actually 7 or more)

1. Work history
2. Third party observations
3. Doctors reports
4. Daily activities
5. Elements of Pain
 - a. Duration (seconds – days)
 - b. Frequency (1 x/sec/min/hour/day/week/month/year)

- c. Intensity (1-10)
 - d. Location (chest, low back, etc)
 - e. Brought on by... (stress, kick, doing lawn, Etc)
 - f. Relieved by... (hot shower, cold pack, music, rest, Rx)
6. Medication
- a. Name (Hydrocodone, HCTZ, Praxil...)
 - b. Dosage (10mg..)
 - c. Frequency (Twice a Day, As Needed, Before bed, etc)
 - d. Lasts (couple hours and back)
 - e. Side Effects (nausea, vomit, sleepy, woozy, etc.)
7. Impact of Pain – functional restrictions
- a. Stop doing...
 - b. Lose focus; concentration
 - c. Forget what I was shopping for; memory
 - d. Takes me longer to... ; pace
 - e. Leave the wedding ; socialize

All these questions should be asked by the ALJ (or representative) to give the reviewing body a clear record for review of credibility with respect to pain. This takes time. Hearings are being scheduled every hour. Not much time to make a full and fair record of an individual's problems that prevent working at a job. And make that 500 goal and 2:00 tee time.

Pp.18-19 Elements totally unrelated to proof of disability often color a Court's decision to remand a case. Namely, sympathy, poverty, situation – just like any jury. In addition, collusive fraud can rear a very ugly head in disability claims such as the Vietnamese in LA, the Black Lung X-Rays in Southern Illinois, the ALJ who grants benefits to clients of certain attorneys. See: fn 268 (p.35) for more examples.

pp.22-23. Does the APA apply to SS proceedings? Are Chevron standards in control when SS adopts rules? If District Courts are misapplying the rule, why doesn't SSA appeal? Same for misapplied 9th Circuit rulings. SSA talks a good game but backs down when faced with a possible loss.

pp.24-32 The Erosion of the Bases for... the Rule

Dr. Welby is still dead and the Insurance companies and managed care groups are taking over health care. There is no REAL attending & treating physician anymore.

May be true. But enterprising advocates can get around that barrier by reviewing and summarizing the medical conditions in a draft form for the NA to review before having transferred to the doctors letterhead and signed by the AP. In the past, with much success, I have submitted the following to A&T Physicians with a CYA cover letter:

Judge ALJ.:

I am the attending and treating physician for John Jones since 1492. Since his first visit and evaluation, I have seen him in the office and hospital settings over 23 times, not including phone conversations with his wife and family. He has asked me to write you regarding his ability to go back to work. Based on a review of the following medical records:

Office visit notes from the following dates..

Test results from CT Scan, MRI, Blood Tests, X-Rays, Voodoo reports and...

Consulting and Referring medical reports from specialists I had him see...

Hospital admit sheets, discharge summaries from UChi, NW, Mayo and...

{copies of these records are attached along with my CV}

With a reasonable degree of medical certainty, it is my considered medical opinion and that Mr. Jones cannot work at any regular job on a 9-5 basis, 5 days a week dues to a combination of medical problems:

1. Coronary Artery disease reducing the flow of blood in two main arteries even after corrective surgery and a combination of therapy and medication. He has a Class II NYHA assessment with diminished capacity for lifting and carrying more than 10 pounds on a regular basis. He has been advised to reduce exposure to stressful encounters and to follow medication intake with restful activity.
2. Diabetes Mellitus Class II, Adult Onset with episodic dizzy spells and fatigue in spite of medication as prescribed as well as dietetic restrictions with 5 meals a day. Such neuropathetic episodes include loss of gait and station with falls, as witnessed by his wife and children on multiple occasions.

3. 20% Loss of Visual Acuity as described in the Ophthalmological report as attached

Mr. Jones, 5'10", 210#, Right hand dominant, 54 year old married male, has a 12th grade education from St. George High School. Since his cardiac episode of 1/1/11, he has been unable to return to work as a professional candy stripper at Evanston Hospital. In spite of ongoing medical care and continued monitoring, the prognosis is considered guarded for any long term improvement.

Should you have any additional questions about the severity of his conditions, please contact my Nurse Assistant, Kim McCabe, at 1 800-772-1213 and she will contact me as soon as possible.

Marcus Welby, MD, FACP, PhD, JD

Cc: John Jones

CC: David R. Bryant esq.

NOTE: To my chagrin, one doctor signed the blank paper draft and sent it directly to the Judge instead of back to me on his letterhead.

This battle of the forms (see: fn 271, p.36) can get crazy and doctors are now charging to fill them out:

ADULT PHYSICAL RESIDUAL FUNCTIONAL CAPACITY

To: _____ (doctor)

If attending and treating physician, initial here _____ and attach your CV

Re: _____ (patient)

SSN: _____ Date of Birth: _____

Please answer the following questions concerning your patient's impairments and abilities. Attach all relevant medical records that have not been previously provided to Social Security. In addition, please list any other medical records you have reviewed in making these assessments:

1. Length & frequency of contact: _____

2. Diagnoses: _____

3. Prognosis: _____

4. My patient's credible symptoms: _____

5. If pain is a symptom, characterize the nature (shooting, aching, etc.), location (chest, back, etc.), frequency (twice a day/week/month/year), duration (seconds, minutes, hours) precipitating factors (sneeze, exercise, fall, stress, etc.), ways of relief (Rx, rest, hot bath, bio feedback, music, etc.), and severity (6 on a 1-10 scale, severe, moderate, mild, etc.) [USE THE BACK OF THIS SHEET IF MORE SPACE NEEDED]

6. The clinical findings and objective signs include: _____

7. Describe the past treatment and response, including any side effects of medications that could impact a work environment (drowsy, dizzy, nausea, etc): _____

8. Have the medical problems diagnosed lasted a year or longer? Expected to last longer than a year? Have a greater than 50% chance of resulting in death? _____

9. Have any mental factors entered into your patient's condition? _____

___ Depression ___ Anxiety ___ Personality ___ Other

If so, explain: _____

10. Do you find your patient to be a reliable author of symptoms and signs reasonably related to the underlying medical problems (ie credible)? ___ Yes ___ No

If not, please elaborate _____

11. How often during the day does your patient indicate experiences of symptoms, such as pain, severe enough to interfere with attention to, concentration on, or pace of activities of daily living (ie. Performance of simple work tasks)?

___ Never ___ Rarely ___ Occasionally ___ Frequently ___ Constantly

These terms are often used loosely. Here, "rarely" means 1% to 5% of the 8 hours in a working day; "occasionally" means 6% to 33%; "frequently" means 34% to 66%

12. In your considered medical opinion, how would stress impact your patient's ability to work at a normal job?

___ Not at all ___ Somewhat if low stress ___ Moderate impact ___ Incapable of any

13. If you can, please assess your patient's functional limits in sitting, standing, walking during a normal 8 hour workday

p.35 Who is a "treating source"? If Dr. Welby belongs to a group and Mr. Jones is seen by the "group" on a rotating basis, can Dr. Welby be considered a "treating source"? If Dr. Welby sent Mr. Jones to Mayo and he stayed for 4 years but kept in touch with the Mayo doctors, can he be considered the "treating source"? The courts seem to be all over the place but are making decision on a case by case basis. Many courts seem to discount a State agency doctor's opinion, even if an examining one, since there is NO doctor patient relationship, there is no fiduciary relationship. Giving what weight to which doctor in the SSA context of deciding a person disabled or not is the crux of the discussion.

As much as Dr. Welby still gets around, he still has not confronted the impact of Obama Care on the health care system. Nor has Dean Krent.

The "routine deference" as suggested by Dean Krent, to the treating physician is not as "routine" as one might suppose in reality.

ALTERNATIVE SUGGESTION: Leave it alone. It ain't broke. Live with the 54% as a price of making ALJs explain why Dr. Welby is wrong.

DRAFT 3/4/13 drb