Administrative Conference of the United States

EVALUATING SUBJECTIVE SYMPTOMS IN DISABILITY CLAIMS
REPORT APPENDICES

Final Report: March 12, 2015

VIII. APPENDICES

A. Changes to SSA's Subjective Symptom Regulations since 1991

20 C.F.R. § 404.1529, How we evaluate symptoms, including pain. (As amended through 2014.)

(a) General. In determining whether you are disabled, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with the objective medical evidence, and other evidence. By objective medical evidence, we mean medical signs and laboratory findings as defined in § 416.928(b) and (c). By other evidence, we mean the kinds of evidence described in §§ 416.912(b)(2) through (8) and 416.913(b)(1), (4), and (5), and (d). These include statements or reports from you, your treating or nontreating source, and others about your medical history, diagnosis, prescribed treatment, daily activities, efforts to work, and any other evidence showing how your impairment(s) and any related symptoms affect your ability to work (or, if you are a child, your functioning). We will consider all of your statements about your symptoms, such as pain, and any description you, your treating source or nontreating source, or other persons may provide about how the symptoms affect your activities of daily living and your ability to work (or, if you are a child, your functioning). However, statements about your pain or other symptoms will not alone establish that you are disabled; there must be medical signs and laboratory findings which show that you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings and statements about how your symptoms affect you. (Section 416.927 explains how we consider opinions of your treating source and other medical opinions on the existence and severity of your symptoms, such as pain.) We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work (or if you are a child, your functioning).

(b) Need for medically determinable impairment that could reasonably be expected to produce your symptoms, such as pain. Your symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, will not be found to affect your ability to do basic work activities unless medical signs or laboratory findings show that a medically determinable impairment(s) is present. Medical signs and laboratory findings, established by medically acceptable clinical or laboratory diagnostic techniques, must show the existence of a medical impairment(s) which results from anatomical, physiological, or psychological abnormalities and which could reasonably be expected to produce the pain or other symptoms alleged. In cases decided by a State agency (except in disability hearings under §§ 416.1414 through 416.1418 of this part and in fully favorable determinations made by State agency disability examiners alone under § 416.1015(c)(3) of this part), a State agency medical or psychological consultant or other medical or psychological consultant designated by the Commissioner directly participates in determining whether your medically determinable impairment(s) could reasonably be expected to produce your alleged symptoms. In the disability hearing process, a medical or psychological consultant may provide an advisory assessment to assist a disability hearing officer in determining whether your impairment(s) could reasonably be expected to produce your alleged symptoms. At the administrative law judge hearing or Appeals Council level of the administrative review process, the adjudicator(s) may ask for and consider the opinion of a medical or psychological expert concerning whether your impairment(s) could reasonably be expected to produce your alleged symptoms. The finding that your impairment(s) could reasonably be expected to produce your pain or other symptoms does not involve a determination as to the intensity, persistence, or functionally limiting effects of your symptoms. We will develop evidence regarding the possibility of a medically determinable mental impairment when we have information to suggest that such an impairment exists, and you allege pain or other symptoms but the medical signs and laboratory findings do not substantiate any physical impairment(s) capable of producing the pain or other symptoms.
(c) Evaluating the intensity and persistence of your symptoms, such as pain, and determining the extent to which your symptoms limit your capacity for work or, if you are a child, your functioning--

(1) General. When the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain, we must then evaluate the intensity and persistence of your symptoms so that we can determine how your symptoms limit your capacity for work or, if you are a child, your functioning. In evaluating the intensity and persistence of your symptoms, we consider all of the available evidence, including your history, the signs and laboratory findings, and statements from you, your treating or nontreating source, or other persons about how your symptoms affect you. We also consider the medical opinions of your treating source and other medical opinions as explained in § 416.927. Paragraphs (c)(2) through (c)(4) of this section explain further how we evaluate the intensity and persistence of your symptoms and how we determine the extent to which your symptoms limit your capacity for work (or, if you are a child, your functioning) when the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain.

(2) Consideration of objective medical evidence. Objective medical evidence is evidence obtained from the application of medically acceptable clinical and laboratory diagnostic techniques, such as evidence of reduced joint motion, muscle spasm, sensory deficit or motor disruption. Objective medical evidence of this type is a useful indicator to assist us in making reasonable conclusions about the intensity and persistence of your symptoms and the effect those symptoms, such as pain, may have on your ability to work or, if you are a child, your functioning. We must always attempt to obtain objective medical evidence and, when it is obtained, we will consider it in reaching a conclusion as to whether you are disabled. However, we will not reject your statements about the intensity and persistence of your pain or other symptoms or about the effect your symptoms have on your ability to work (or if you are a child, to function independently, appropriately, and effectively in an age-appropriate manner) solely because the available objective medical evidence does not substantiate your statements.

(3) Consideration of other evidence. Since symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. The information that you, your treating or nontreating source, or other persons provide about your pain or other symptoms (e.g., what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions which you, your treating or nontreating source, or other persons report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your treating or nontreating source, and observations by our employees and other persons. If you are a child, we will also consider all of the evidence presented, including evidence submitted by your treating, examining or consulting physician or psychologist, information from educational agencies and personnel, statements from parents and other relatives, and evidence submitted by social welfare agencies, therapists, and other practitioners. Section 416.927 explains in detail how we consider and weigh treating source and other medical opinions about the nature and severity of your impairment(s) and any related symptoms, such as pain. Factors relevant to your symptoms, such as pain, which we will consider include:

(i) Your daily activities;

(ii) The location, duration, frequency, and intensity of your pain or other symptoms;

(iii) Precipitating and aggravating factors;

(iv) The type, dosage, effectiveness, and side effects of any medication you take or have taken to alleviate your pain or other symptoms;

(v) Treatment, other than medication, you receive or have received for relief of your pain or other symptoms;

(vi) Any measures you use or have used to relieve your pain or other symptoms (e.g., lying flat on your back,

standing for 15 to 20 minutes every hour, sleeping on a board, etc.); and

(vii) Other factors concerning your functional limitations and restrictions due to pain or other symptoms.

(4) How we determine the extent to which symptoms, such as pain, affect your capacity to perform basic work activities, or, if you are a child, your functioning). In determining the extent to which your symptoms, such as pain, affect your capacity to perform basic work activities (or if you are a child, your functioning), we consider all of the available evidence described in paragraphs (c)(1) through (c)(3) of this section. We will consider your statements about the intensity, persistence, and limiting effects of your symptoms, and we will evaluate your statements in relation to the objective medical evidence and other evidence, in reaching a conclusion as to whether you are disabled. We will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between your statements and the rest of the evidence, including your history, the signs and laboratory findings, and statements by your treating or nontreating source or other persons about how your symptoms affect you. Your symptoms, including pain, will be determined to diminish your capacity for basic work activities (or, if you are a child, your functioning) to the extent that your alleged functional limitations and restrictions due to symptoms, such as pain, can reasonably be accepted as consistent with the objective medical evidence and other evidence.

(d) Consideration of symptoms in the disability determination process. We follow a set order of steps to determine whether you are disabled. If you are not doing substantial gainful activity, we consider your symptoms, such as pain, to evaluate whether you have a severe physical or mental impairment(s), and at each of the remaining steps in the process. Sections 416.920 and 416.920a (for adults) and 416.924 (for children) explain this process in detail. We also consider your symptoms, such as pain, at the appropriate steps in our review when we consider whether your disability continues. The procedure we follow in reviewing whether your disability continues is explained in § 416.994 (for adults) and § 416.994a (for children).

(1) Need to establish a severe medically determinable impairment(s). Your symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, are considered in making a determination as to whether your impairment or combination of impairment(s) is severe. (See § 416.920(c) for adults and § 416.924(c) for children.)

(2) Decision whether the Listing of Impairments is met. Some listed impairments include symptoms usually associated with those impairments as criteria. Generally, when a symptom is one of the criteria in a listing, it is only necessary that the symptom be present in combination with the other criteria. It is not necessary, unless the listing specifically states otherwise, to provide information about the intensity, persistence, or limiting effects of the symptom as long as all other findings required by the specific listing are present.

(3) Decision whether the Listing of Impairments is equaled. If your impairment is not the same as a listed impairment, we must determine whether your impairment(s) is medically equivalent to a listed impairment. Section 416.926 explains how we make this determination. Under § 416.926(b), we will consider medical equivalence based on all evidence in your case record about your impairment(s) and its effects on you that is relevant to this finding. In considering whether your symptoms, signs, and laboratory findings are medically equal to the symptoms, signs, and laboratory findings of a listed impairment, we will look to see whether your symptoms, signs, and laboratory findings are at least equal in severity to the listed criteria. However, we will not substitute your allegations of pain or other symptoms for a missing or deficient sign or laboratory finding to raise the severity of your impairment(s) to that of a listed impairment. (If you are a child and we cannot find equivalence based on medical evidence only, we will consider pain and other symptoms under §§ 416.924a and 416.926a in determining whether you have an impairment(s) that functionally equals the listings.) Regardless of whether you are an adult or a child, if the symptoms, signs, and laboratory findings of your impairment(s) are equivalent in severity to those of a listed impairment, we will find you disabled. (If you are a child and your impairment(s) functionally equals the listings under the rules in § 416.926a, we will also find you disabled.) If they are not, we will consider the impact of your symptoms on your residual functional capacity if you are an adult. (See paragraph (d)(4) of this section.)

(4) Impact of symptoms (including pain) on residual functional capacity or, if you are a child, on your functioning. If you have a medically determinable severe physical or mental impairment(s), but your impairment(s) does not meet or equal an impairment listed in appendix 1 of subpart P of part 404 of this

chapter, we will consider the impact of your impairment(s) and any related symptoms, including pain, or your residual functional capacity, if you are an adult, or, on your functioning if you are a child. (See §§ 416.945 and 416.924a–416.924b.)

B. Additional Policies Implicating Subjective Symptom Evaluation

The report's focus is not limited based on the medical impairment alleged or experienced by claimants. However, the scope of work did not include specific analysis of SSA's existing sub-regulatory policies on:

- *SSR 14-1p, Titles II and XVI, Evaluating Cases Involving Chronic Fatigue Syndrome (CFS)*[1]—Establishing specific criteria that establish the medically determinable impairment of chronic fatigue syndrome (and mylagic encephalomyelitis), a systemic disorder consisting of a complex of symptoms that may vary in frequency, duration, and severity. Describing the two-step symptom evaluation process and referencing SSR 96-7p.

- *SSR 12-2p, Titles II and XVI: Evaluation of Fibromyalgia*[2]—Setting forth specific criteria that establish the medically determinable impairment of fibromyalgia, a complex medical condition characterized primarily by widespread pain in the joints, muscles, tendons, or nearby soft tissues that have persisted for at least three months. Describing the two-step symptom evaluation process and referencing SSR 96-7p.

- *SSR 06-3p, Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies*[3]—Detailing guidelines for the evaluation of evidence from "other sources," including spouses, parents and caregivers, siblings, other relatives, friends, neighbors, clergy, and employers. This ruling does not discuss SSR 96-7p and evaluation of evidence regarding subjective symptoms given by "other sources" but it is worth noting that symptom evaluation may require findings regarding third party credibility and that subjective symptom-related remands sometimes pivot on evidence from "other sources." The ruling identifies statements from physicians and psychologists or other "'acceptable medical sources' that reflect judgments about the nature and severity of an individual's impairments(s), including symptoms, diagnosis, and prognosis" as "medical opinions." Opinions from "other medical sources" or "other sources" may also describe symptoms.

- *SSR 03-2p, Titles II and XVI: Evaluating Cases Involving Reflex Sympathetic Dystrophy Syndrome/Complex Regional Pain Syndrome*—Establishing specific criteria that establish the medically determinable impairment of Reflex Sympathetic Dystrophy Syndrome (RSDS), also frequently known as Complex Regional Pain Syndrome, Type I (CRPS), a chronic pain syndrome. Stating that "an individual's symptoms and the effect(s) of those

[1] SSR 14-1p, Titles II and XVI: Evaluating Claims Involving Chronic Fatigue Syndrome (CFS), 79 Fed. Reg. 18,750 (Apr. 3, 2014).
[2] SSR 12–2p, Titles II and XVI: Evaluation of Fibromyalgia, 77 Fed. Reg. 43,640 (July 25, 2012).
[3] SSR 06-3p, Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies, 71 Fed. Reg. 45, 593 (Aug. 9, 2006).

> symptoms on the individual's ability to function must be considered both in determining impairment severity and in assessing the individual's residual functional capacity (RFC), as appropriate."[4] Referencing SSR 96-7p and the symptom evaluation process requirements contained therein.[5]

Nonetheless, the recommendations in this report may implicate these SSRs to the extent that they rely on SSR 96-7p or require credibility evaluations. Similarly, they may also implicate a number of internal agency guidance documents, such as the Programs Operations Manual System (POMS), that address the symptom evaluation process.

[4] SSR 03-2p, Titles II and XVI: Evaluating Cases Involving Reflex Sympathetic Dystrophy Syndrome/Complex Regional Pain Syndrome, 68 Fed. Reg. 59, 971 (Oct. 20, 2003).
[5] *Id*.

C. The Electronic Claims Analysis Tool

This appendix contains a number of screenshots taken from SSA's Electronic Claims Analysis Tool (eCAT). They illustrate the questions users are prompted to answer in evaluating claimants' subjective symptoms. Each screenshot shows a navigation bar at the top and on the user's left hand side of the screen. Users can click on each of the sections labelled to move between various questions they are to answer in evaluating a disability claim.

In order for the Symptoms and Credibility portion of eCAT to display a user must have documented at least one medically determinable impairment in the Impairment Severity / Sign section of the program.[1] If the user has not documented a medically determinable impairment they are told that they must prior to consideration of Symptoms and Credibility. NADE suggested that the Symptoms and Credibility section of eCAT should immediately follow determination of the medically determinable impairment, prior to the medical disposition section.[2] It is worth noting that this is the section of eCAT that contains case analyses and RFC/Mental RFC Assessments,[3] some of which may include credibility evaluations as unstructured data.[4]

Symptoms and Credibility

"Can one or more of the individual's medically determinable impairment(s) (MDI(s)) reasonably be expected to produce the individual's pain or other symptoms?" – answered "No"

[1] Soc. Sec. Admin., ECAT User Manual 9.0, 161(Aug. 08, 2014).
[2] Letter from Jeffrey Price, President, National Association of Disability Examiners, to Stephanie Tatham, Attorney Advisor, Admin. Conf. of the U.S., at 2 (Nov. 4, 2014) ("NADE suggests the Electronic Claims Analysis Tool (ECAT) should be modified so that it can be optimally utilized as a tool to address the credibility of a claimant's statement. Since the issue of credibility is to be considered in assessing the claimant's condition once there is a Medically Determinable Impairment (MDI), we believe it would be better to have the credibility section to be located immediately following the MDI and prior to the medical disposition section. A revision in ECAT of the symptoms and credibility page would also help avoid any potential confusion by the adjudicator. Due to the current logical pathing of ECAT in the symptoms and credibility section, the adjudicator must answer questions correctly to consider all the factors and assess the credibility of the individual's statements. We believe there would be less confusion if all the questions were available on the page without having to answer the other questions.").
[3] Soc. Sec. Admin., ECAT User Manual 9.0, 115 (Aug. 08, 2014).
[4] *E.g.*, SSA, *RPC Cases—0214-065, 0913-108, 113-036* (Case Analyses) and *0114-065, 0214-016* (RFC).

"Can one or more of the individual's medically determinable impairment(s) (MDI(s)) reasonably be expected to produce the individual's pain or other symptoms?" – answered "Yes"

Search New Case | Save | Preview DDE | MAT | Print Screen | Spell Check | Toggle Size | View FOFAE | Exit

Claim Communications (0) - n/a | Select Claim Types DI DIB | Helpful Links

Claim Type: DIB

New Evidence Received

Claimant Information

Technical Issues

Evidence of Record

Consultative Exams

Findings and Analysis

Impairment Severity/Sign

Symptoms and Credibility

Weighing Opinion Evidence

Reconciling Source Opinion

Past Relevant Work

Other Work

Determination

Claim Communications

eCAT

Training

Build No: 9.1.6

Symptoms and Credibility

Evaluate the individual's statements about symptoms and their functional effects and, if required, the credibility of the individual's statement(s).
(20 CFR 404.1529; 20 CFR 416.929; SSR 96-7p)

Can one or more of the individual's medically determinable impairment(s) (MDI(s)) reasonably be expected to produce the individual's pain or other symptoms?

(●) Yes ( ) No ( ) Not Yet Answered

Are the individual's statements about the intensity, persistence, and functionally limiting effects of the symptoms substantiated by the objective medical evidence alone?

( ) Yes (●) No ( ) Not Yet Answered

Whenever the individual's statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, the adjudicator must make a finding on the credibility of the individual's statements based on a consideration of the entire case record (SSR 96-7p)

When considering the following factors, which were the most informative in assessing the credibility of the individual's statements?

- [ ] ADLs
- [ ] The location, duration, frequency and intensity of the individual's pain and other symptoms
- [ ] Precipitating and aggravating factors
- [ ] Medication Treatment
- [ ] Treatment other than medication
- [ ] Other Measures to relieve symptoms
- [x] Other factors

Use sentences to explain:

Text...

243 / 250

"What is your assessment of the credibility of the individual's statements regarding symptoms considering the total medical and non-medical evidence in file?" – answered "Fully Credible"

Training

Build No: 9.1.6

What is your assessment of the credibility of the individual's statements regarding symptoms considering the total medical and non-medical evidence in file?

(●) Fully Credible

( ) Not Credible

( ) Partially Credible

( ) Symptoms Durational - Resolving

( ) Other

( ) Not Yet Answered

Explain the credibility assessment:

3900 / 3900

Spell Check | View FOFAE | Exit | Previous | Next

D. Summary of Request for Program Consultation Files Discussing Subjective Symptom Evaluation

Case Number	Deficiency type (identified by quality reviewers)	ODP resolution	Did ODP require additional record development?	Was DDS subjective symptom evaluation policy complaint?	ODP comments on subjective symptom evaluation (paraphrased)
1213-071	Decisional	Deficiency affirmed	Yes	No - DDS reached incorrect conclusion when analyzing claimant's subjective symptoms	DDS must obtain additional evidence. Claimant has medically determinable impairments that could reasonably result in pain. DDS found claimant not to be credible, but her statements concerning pain are credible and supported by evidence. The DDS should consider these factors, develop a complete medical history, then make a determination.
0114-034	Decisional	Deficiency affirmed	No	No - conclusory language	DDS should proceed with an allowance in accordance with the quality reviewers' instructions. When conducting subjective symptom evaluation, DDS found the claimant's statements regarding his symptoms to be "partially credible," but did not indicate specific evidence-based reasons for the proposed finding.
0214-065	Decisional	Deficiency affirmed	No	No - conclusory language	DDS will process the claim as a denial and amend medical residual functional capacity to reflect the quality reviewers' proposed limitations. DDS indicated that the claimant's statements were "partially credible," but did not provide a detailed rationale for its findings. DDS also failed to address opinion evidence from consultative examination providers, which may indicate the claimant is exaggerating his symptoms.
0913-108	Decisional	Deficiency affirmed	No	No - DDS reached incorrect conclusion when analyzing claimant's subjective symptoms	DDS will process claim as denial using the quality reviewers' proposed residual functional capacity. The evidence shows inconsistent storytelling and actions by claimant, alleged impairments with no objective findings, and intentional false presentation on exam. "Based on his overall presentation at all visits and lack of validity in any of his statements, his statements all appear not credible..." (3) No further development of the record is necessary.

Case Number	Deficiency type (identified by quality reviewers)	ODP resolution	Did ODP require additional record development?	Was DDS subjective symptom evaluation policy complaint?	ODP comments on subjective symptom evaluation (paraphrased)
1113-028	Decisional	Deficiency affirmed	No	No - conclusory language	DDS will allow claim as described above. DDS found that the claimant was not "fully credible," but did not discuss which statements were credible and which were not, and why.
1113-036	Decisional	Deficiency affirmed	No	No - conclusory language	DDS will process an unfavorable determination in accordance with the quality reviewers' request for correction actions. DDS found claimant to be credible, but did not properly assess claimant's subjective symptoms. Based on the evidence in the file (including inconsistencies in records and statements), claimant's statements are not credible, and the quality reviewer's proposed residual functional capacity is appropriate.
0114-065	Decisional	Deficiency rescinded	Yes	Subjective symptoms not discussed by ODP	ODP did not address subjective symptom evaluation issues. Quality reviewer's assessment of subjective symptoms issues not apparent upon review.
0214-016	Decisional	Deficiency rescinded	Yes	No - conclusory language	DDS must gather additional medical information. DDS suggests that the claimant's statements are "partially credible," and that exertional limitations alleged by claimant are not fully substantiated. However, DDS does not cite specific statements or provide specific reasons for its findings.
0314-058	Decisional	Deficiency rescinded	Yes	No - conclusory language	DDS will make a reasonable effort to obtain a complete medical history and will obtain additional information about claimant's abilities. Once additional information is obtained, DDS will reassess the claim. DDS did not properly consider the claimant's ongoing pursuit of treatment for chronic pain, and did not explain which of the claimant's alleged symptoms were credible, or not credible, and why.

Case Number	Deficiency type (identified by quality reviewers)	ODP resolution	Did ODP require additional record development?	Was DDS subjective symptom evaluation policy complaint?	ODP comments on subjective symptom evaluation (paraphrased)
0214-059	Decisional	Deficiency rescinded	No	No - conclusory language	DDS will process original determination but must project claimant's residual functional capacity. Claimant's complaints of pain were consistent over time, and evidence indicates limitation to less than a full range of sedentary work. Neither the quality reviewers nor DDS provided policy compliant subjective symptom evaluations per SSR 96-7p.
0314-007	Decisional	Deficiency rescinded	No	Yes	DDS will proceed with allowance. The quality reviewers did not adequately assess claimant's pain claims. Reviewers must evaluate the extent to which the claimant's medically determinable impairment limits the claimant's activities. The absence of objective medical evidence supporting an individual's statements about pain or other symptoms is only one factor that the adjudicator must consider. The adjudicator must consider objective medical evidence in the context of all evidence.
1013-027	Decisional	Deficiency rescinded	No	No - conclusory language	DDS will correct the residual functional capacity and allow the claim. DDS did not correctly assess claimant's statements about her subjective symptoms. The allowance stands.
0114-006	Documentation	Deficiency affirmed	Yes	No - conclusory language	DDS must continue development then re-assess the claim. When conducting subjective symptom evaluation, DDS must consider symptoms, such as pain, that suggest a greater severity of impairment than can be shown by medical evidence alone. DDS must consider claimant's statements concerning symptoms and must identify specific reasons, grounded in evidence, for its subjective symptom evaluation. This information must be sufficiently specific for subsequent reviewers to understand the basis of the finding. Evidence indicates greater severity of impairment than initially found by DDS: pain complaints by claimant have been consistent over time and unquestioned by treating source physicians.

Case Number	Deficiency type (identified by quality reviewers)	ODP resolution	Did ODP require additional record development?	Was DDS subjective symptom evaluation policy complaint?	ODP comments on subjective symptom evaluation (paraphrased)
0114-050	Documentation	Deficiency affirmed	Yes	No - further evidence needed for subjective symptom evaluation	DDS must gather additional medical information. Once DDS receives new medical evidence, DDS must re-evaluate the clam and prepare a policy compliant subjective symptom evaluation in accordance with SSR 96-7p.
0114-077	Documentation	Deficiency affirmed	Yes	No - further evidence needed for subjective symptom evaluation	DDS should proceed with additional development, and project the claimant's residual functional capacity. DDS must consider borderline age, if warranted. Updated activities of daily living statements are needed in order to properly conduct subjective symptom evaluation. The existing assessment is based on out of date activities of daily living statements and was not policy compliant.
0913-055	Documentation	Deficiency affirmed	Yes	No - conclusory language	DDS needs to make a reasonable effort to obtain all outstanding medical evidence of record and provide a policy-compliant subjective symptom evaluation. DDS must provide a policy compliant assessment.
1013-028	Documentation	Deficiency affirmed	Yes	No - conclusory language; further evidence needed for subjective symptom evaluation	DDS will obtain additional vocational documentation. In the disability determination explanation, DDS did not perform a proper assessment of subjective symptoms. The quality reviewers did not properly address subjective symptoms either.
1113-018	Documentation	Deficiency affirmed	Yes	No - further evidence needed for subjective symptom evaluation	DDS should proceed with additional development as recommended by the quality reviewers. DDS should implement recommendation made by the quality reviewers in part because it complies with subjective symptom evaluation policy.
1213-026	Documentation	Deficiency affirmed	Yes	No - further evidence needed for subjective symptom evaluation	DDS will undertake further development as described then adjudicate claim. Claimant alleges pain and has a medically determinable impairment that could cause pain. DDS should follow policy to conduct subjective symptom evaluation by considering all evidence.

Case Number	Deficiency type (identified by quality reviewers)	ODP resolution	Did ODP require additional record development?	Was DDS subjective symptom evaluation policy complaint?	ODP comments on subjective symptom evaluation (paraphrased)
1213-027	Documentation	Deficiency affirmed	Yes	No - conclusory language	DDS should proceed with additional development as outlined above. Existing disability determination explanation does not contain a policy-compliant discussion with evidence-based support for subjective symptom evaluation.
1213-041	Documentation	Deficiency affirmed	Yes	No - further evidence needed for subjective symptom evaluation	DDS will obtain additional information as outlined above and reevaluate claim. If development results in an allowance, DDS must address drug and alcohol addiction. Subjective symptoms addressed indirectly. DDS suspected the claimant of faking his test scores on IQ tests, and suggested that both claimant and mother made unsubstantiated statements regarding symptoms. ODP commented that inconsistencies in the record made it difficult to determine the severity of the claimant’s impairment, and instructed DDS to attempt to verify information contained in suspected test results.
1213-049	Documentation	Deficiency affirmed	Yes	No - conclusory language; further evidence needed for subjective symptom evaluation	DDS will obtain additional documentation. DDS did not properly conduct subjective symptom evaluation. DDS must obtain additional test results and activities of daily living statements to determine severity of claimant’s impairment.
0114-029	Documentation	Deficiency rescinded	Yes	No - further evidence needed for subjective symptom evaluation	DDS will pursue additional evidence then readjudicate claim. After obtaining additional information on claimant’s mental impairment, DDS must conduct subjective symptom evaluation by using the third-party activities of daily living statements and all other available information. DDS must assess the claimant's mental residual functional capacity.

Case Number	Deficiency type (identified by quality reviewers)	ODP resolution	Did ODP require additional record development?	Was DDS subjective symptom evaluation policy complaint?	ODP comments on subjective symptom evaluation (paraphrased)
0913-102	Documentation	Deficiency rescinded	Yes	Subjective symptoms not discussed by ODP	ODP did not address subjective symptom evaluation issues but found that the DDS should proceed with additional development to determine scope of claimant's limitations. The quality reviewer identified inconsistencies in the record pertaining to the claimant's current mental functioning, and directed DDS to obtain additional information to resolve inconsistencies (DDS had identified the inconsistencies, but found claimant "fully credible").
0114-005	Documentation	Deficiency rescinded	No	Yes	DDS will allow claim as proposed. SSA recognizes that the intensity of a claimant's symptoms may be more severe than can be shown by the objective medical evidence alone. The Claimant has been consistent in searching for relief for her back pain, and has worked with some pain in the past. Claimant's activities of daily living are confirmed by a friend, and the field officer observation "lends credence to her alleged pain induced restrictions" (p. 3). Claimant's alleged symptom-related limitations are credible when considering all the evidence.
1213-021	Documentation	Deficiency rescinded	No	Yes	ODP did not discuss subjective symptoms. The quality reviewers found insufficient evidence to evaluate claimant's impairment, and requested that DDS obtain a stress test to assess severity of impairment and to determine credibility of claimant's allegations. ODP determined that DDS will proceed with allowance determination as proposed.

E. ODAR Data on Subjective Symptom-Related Remands[1]

Appeals Council request for review remands

The Social Security Appeals Council frequently remands ALJ decisions it reviews. Remands occurred in approximately twenty percent (20%) of requests for review considered by the Appeals Council over the period from FY 2009 to FY 2013 (129,884 remands of 660,391 total dispositions). The percentage of cases remanded declined from a high of twenty-two percent (2%) in FY 2009 to seventeen percent (17%) in FY 2013.

Between FY 2009 and FY 2012, there were 106,853 hearing office receipts of Appeals Council remands.[2] Credibility evaluation was the fifth most frequently cited reason for Appeals Council remands, as coded at the hearing office level, between FY 2009 and FY 2012. It was a reason for remand in at least 18,744 Appeals Council decisions.[3] By this measure, credibility evaluation was a factor in at least eighteen percent (18%) of Appeals Council remands received and coded at the hearing office level between FY 2009 to FY 2012.

The most commonly cited subjective symptom-related remand reason coded at the hearing office level for Appeals Council remands between FY 2009 and FY 2012 was *claimant credibility—failed to discuss appropriate credibility factors* (18,744 cases). *Claimant credibility—other issue* was cited in 3,675 cases (3%); *claimant credibility—failed to acknowledge unavailability of treatment* was the third most commonly cited claimant credibility reason for remand, and was cited in only 237 coded cases. Third party credibility determinations were a basis for remand in at least 3,480 coded cases (3%).[4]

[1] All data for this analysis was provided by SSA's Office of Disability and Adjudication Review. SSA's data contains additional cases for a week in calendar year 2011 that occurred between FY2011 and FY 2012. This data was uniformly excluded from analysis. The percentage of cases coded for remand reason is unknown and it is possible that remand rates are higher than reported.

[2] There is a slight variance in the number of cases remanded each year by the Appeals Council and the number of Appeals Council remands received and coded by the Hearing Offices each year.

[3] Importantly, the reason for remand label was most frequently "Label Missing", meaning that the field was left blank in 44,547 remanded cases over the same time period. It is possible that the frequency with remand reasons are cited varies in those remands that were not categorized and that full coding could change the frequency and remand rate results (although absolute remand numbers would likely only increase).

[4] A second dataset provided by SSA separately examined cited claimant credibility reasons on remanded requests for review. This dataset covered FY 2009-FY 2013, and identified many fewer remands than the hearing office data. *Claimant credibility—failed to discuss appropriate credibility factors* was in issue in 11,285 (versus 18,744) cases. *Claimant credibility—other issue* was cited in 2,365 (versus 3,675) cases; *Claimant credibility—failed to acknowledge unavailability of treatment* was the third most commonly cited claimant credibility reason for remand, and was cited in only 156 (versus 237) coded cases. Given the inclusion of an additional year of data, FY 2013, one would expect the number of claimant credibility remands to be higher rather than lower. The basis of this discrepancy was not identified, but hearing office data were primarily used for analysis since it appears that coding is conducted at various agency offices (*i.e.*, at hearing office level, on remand from courts, etc.) to a varying degree and hearing office data appeared to be more complete based on absolute reports of credibility-based remands.

Appeals Council pre-effectuation review remands

The Appeals Council's Division of Quality Review conducts pre-effectuation review of a random sample of social security disability cases. The Appeals Council evaluated 16,696 dispositions between FY 2011 and FY 2013. Of the evaluated cases, the Division of Quality Review took own motion and remanded 2,706 cases, or just over sixteen percent (16%). The overall rate of remand increased in later years, to about nineteen percent (19%) in FY 2013. The number of cases evaluated has also increased each year, doubling from FY 2011 to FY 2012, though only minimally from FY 2012 to FY 2013.

Over the three-year time period, *claimant credibility—failed to discuss appropriate credibility factors* was cited in 557 cases (21% of remanded cases). *Claimant credibility—other issue* was cited in 128 cases (5% of remanded case); *claimant credibility—failed to acknowledge unavailability of treatment* was the third most commonly cited claimant credibility reason for remand but was cited in only two remands.

Judicial remands

Hearing offices received 25,208 remands from courts between FY 2009 and FY 2012, with a slight increase in the number of remands every year (5,938 in FY 2009 to 7,599 in FY 2013). New court case receipts also increased over the same time period. According to hearing office level coding, credibility evaluation was a basis for remand in at least 5,637, or twenty-two percent (22%), of remands.[5] As at the Appeals Council, *claimant credibility—failed to discuss appropriate credibility factors* was the most frequent subjective symptom-related remand reason (5,637 cases). *Claimant credibility—other issue* was the basis for 2,370 remands (9%) and *claimant credibility—failed to acknowledge unavailability of treatment* was the third most frequent reason for a subjective symptom-related remand (102 cases). Third party credibility remand reasons were observed in less than three percent (3%) of remanded cases.

[5] Over the period from FY 2010 to FY 2013, courts remanded cases 25,952 cases. Credibility Evaluation was a basis for remand in 3,085 of FY 2010-FY2013 cases coded at the initial intake level, or at least twelve percent (12%). Again, primary analysis is focused on hearing office coded data, which appears to be more complete (78,321 total hearing office coded reasons for court remands between FY2009-FY2013 versus 43,378 total intake office coded reasons for court remands between FY2009-2013). 20,322 "label missing" coded entries were excluded from analysis.

F. Appellate Case Law Citations

	Boilerplate	Absence of Treatment	Ordinary Activities	Required Objective Medical Evidence of Subjective Symptoms	Unconsidered Subjective Symptom Evidence	Disregarded Supporting Medical Evidence without Adequate Explanation
1st Cir.						
2d Cir.			*Balsamo v. Chater*, 142 F.3d 75, 81 (2d Cir. 1998).	***Meadors v. Astrue*, 370 Fed. Appx. 179, 183-84 (2d Cir. 2010).**		*Burgess v. Astrue*, 537 F.3d 117, 130 (2d Cir 2008).
3d Cir.	*Schaudeck v. Comm'r of SSA*, 181 F.3d 429, 433 (3rd Cir. 1999).	*Beasich v. Comm'r of Soc. Sec.*, 66 Fed. Appx. 419, 430 (3d Cir. 2003).			*Schaudeck v. Comm'r of SSA*, 181 F.3d 429, 435 (3rd Cir. 1999).	
4th Cir.				*Hines v. Barnhart*, 453 F.3d 559, 564 (4th Cir. 2006).		
5th Cir.	*Penson v. Barnhart*, 103 Fed. Appx. 843, 844 (5th Cir. 2004).					
6th Cir.		***Lariccia v. Comm'r of Soc. Sex.*, 549 Fed. Appx. 377, 386 (6th Cir. 2013).**	***White v. Comm'r of Soc. Sec.*, 312 Fed. Appx. 779, 788-89 (6th Cir. 2009).**	***Brooks v. Comm'r of Soc. Sec.*, 531 Fed. Appx. 636, 643 (6th Cir. 2013).**		
7th Cir.	***Bjornson v. Astrue,* 671 F.3d 640, 645 (7th Cir. 2012).**	***Goble v. Astrue*, 385 Fed. Appx. 588, 591 (7th Cir. 2010).**	***Mueller v. Astrue*, 493 Fed. Appx. 772, 777 (7th Cir. 2012).**	***See Bjornson v. Astrue*, 671 F.3d 640, 646 (7th Cir. 2012) (dicta).**	*Ramey v. Astrue*, 319 Fed. Appx. 426, 429 (7th Cir. 2009).	***Martinez v. Astrue*, 630 F.3d 693, 696 (7th Cir. 2011).**
8th Cir.		***Watkins v. Astrue*, 414 Fed. Appx. 894, 896 (8th Cir. 2011).**	*Baumgarten v. Chater*, 75 F.3d 366, 369 (8th Cir. 1996).			
9th Cir.	*Shafter v. Barnhart*, 120 Fed. Appx. 688, 692 (9th Cir. 2005).	*Orn v. Astrue*, 495 F.3d 625, 638 (9th Cir. 2007).	*Orn v. Astrue*, 495 F.3d 625, 639 (9th Cir. 2007).	***Nazzal v. Astrue*, 316 Fed. Appx. 591, 592 (9th Cir. 2009).**		
10th Cir.	*Hardman v. Barnhart*, 362 F.3d 676, 679 (10th Cir. 2004).	*Thompson v. Sullivan,* 987 F.2d 1482, 1490 (10th Cir. 1993).	***Martinez v. Astrue*, 422 Fed. Appx. 719, 728 (10th Cir. 2011).**		***Jones v. Colvin*, 514 Fed. Appx. 813, 823-24 (10th Cir. 2013).**	***Jones v. Colvin*, 514 Fed. Appx. 813, 818-19 (10th Cir. 2013).**
11th Cir.			*Foote v. Chater*, 67 F.3d 1553, 1561 (11th Cir. 1995).			

Bolded cases were identified via the research methodology; non-bolded cases were identified through supplemental research.

G. Stakeholder Questionnaire Responses

1. **Association of Administrative Law Judges National Executive Board, Suggested Responses to ACUS Questionnaire (June 15, 2014).**

2. **Letter from Thomas M. Susman, Director, Governmental Affairs Office, American Bar Association, to Paul R. Verkuil, Chairman, Administrative Conference of the United States (July 2, 2014).**

3. **Response of the National Association of Disability Representatives to the ACUS Symptom Evaluation Questionnaire (June 9, 2014).**

4. **Letter from Cynthia Berger, President, Board of Directors, National Organizations of Social Security Claimants' Representatives and Barbara Silverstone, Executive Director, National Organizations of Social Security Claimants' Representatives, to Stephanie Tatham, Attorney Advisor, Administrative Conference of the United States (June 9, 2014).**

5. **Letter from Jeffrey Price, President, National Association of Disability Examiners, to Stephanie Tatham, Attorney Advisor, Administrative Conference of the United States (November 4, 2014).**

6. **Email from Trudy Lyon-Hart, President, National Council of Disability Determination Directors, to Stephanie Tatham, Attorney Advisor, Administrative Conference of the United States (Oct. 29, 2014).**

SUGGESTED RESPONSES TO ACUS QUESTIONNAIRE

PREPARED BY THE AALJ NATIONAL EXECUTIVE BOARD

- (Questions # 1 and 2) The AALJ's position is that no changes, per se, are required in either the regulations for evaluating the credibility of a claimant's statements about his/her symptoms, including pain (20 C.F.R. §§404.1529, 416.929), or in SSA's current sub-regulatory guidance in that regard as contained in SSR 96-7p. As further described below, however, the AALJ has suggestions regarding how these regulations and policy interpretations should be implemented and administered.

- (Question # 3) The AALJ believes that all of the claimant's physicians should be required to submit, during the initial gathering of medical record in support of a claimant's allegations, a formal physical residual or rehabilitation evaluation, providing detailed descriptions of all exertional, non-exertional, range of movement and other functional limitations of the claimant. If the claimant's treating sources are unwilling or incapable of providing such an evaluation, SSA should pay for a claimant to have a complete physical/functional capacity evaluation, should the judge determine such evidence necessary in the adjudication of the case.

- (Questions # 4 and 8). The AALJ believes the regulation granting the opinion of treating physicians more weight (20 C.F.R. §§404.1527 (d)(2), 416.927(d)(2)) should be abolished, with weight attributed to other factors such as longitudinal treatment, expertise in the field, and extent and duration of examinations. Additionally, the AALJ believes that all records should be submitted, and the record closed, at least five (5) days prior to the hearing, as is currently the practice in the pilot program in Region 1.

- (Question # 5). The AALJ believes that all claimant should be required to completely fill out all questionnaires and other forms detailing the nature, extent and severity of all symptoms and their resulting functional limitations during the initial stage of the disability process, and that all such questionnaires and forms be signed under oath under penalty of perjury. The failure to complete any of these questionnaires and other forms, or the failure to attend consultative examinations, should result in a dismissal of their application for disability benefits, preferably with prejudice.

- (Question # 6). The AALJ believes that judges and their staff should have access to all social media sites. The recent adverse publicity about New York police officer and firefighters claiming disability following their involvement in the September 11, 2001 World Trade Center attacks, while social media showed them deep sea fishing and flying helicopters, plainly reveals the value of social media in gathering information and detecting fraud. Similarly, judges and staff should be permitted to access official internet records concerning the arrest and conviction records of claimants. In this regard, individuals often claim they are free of drug and alcohol use while court records may show recent convictions of such use/abuse. In fact, neither judges nor their staff should be precluded from obtaining relevant information which may bring light to the truth of the matter asserted, which in our case is the alleged disability.

- (Question # 7) The Agency should establish a government representative system, where the Agency would be represented by an advocate during hearings and at the pre-hearing and post-hearing stages. These government representatives should have the time to adequately develop the record prior to a hearing, and bring any inconsistencies or contradictions in the claimants' allegations to the attention of the judge.In the absence of a government representative program, judges should be allowed to vigorously question claimants and other witnesses, without threats of counseling or disciplinary action for being "biased" or "impolite." Additionally, SSA must rescind its policy disallowing psychological tests, such as MMPI II, TOMM and REY-25, that may shed light on whether claimant's may be malingering or exaggerating certain symptoms.

- (Question # 9). The difficulity judges have in evaluating subjective symptoms has not changed. The difficulty is, of course, determining whether claimant's testimony is credible in light of the available medical evidence. Often times, claimants allege symptoms that are impossible to be discounted by a medical profider, such as continued dizziness, fatigue, hallucinations, falls, inability to get along with others, fear of strangers, the ability to use public transportation, and many other. The answer to "judging" the credibility of such asserted symptoms is to provide the judge with sufficient time to review all evidences prior to the hearing to develop appropriate questions for the claimant at hearing and to aggressively examine the claimant based on the judges thorough knowledge of the evidence in the file.. Further, the judge must be give time to order and review appropriate CE's, including tests which assesses such things as symptom magnification, before hearing. Regardless, of regulatory change, it is only the judge that can make the credibility determination and they can only do that correctly if they have sufficient time to review and understand the evidence in the file.The AALJ has no views on this question.

ABA Defending Liberty Pursuing Justice

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July 2, 2014

The Honorable Paul R. Verkuil
Chairman
Administrative Conference of the United States
1120 20th Street, N.W., Suite 706 South
Washington, D.C. 20036

Re: Administrative Conference of the United States Study to Assess Social Security Administration's Laws, Regulations, Policies and Practices Concerning Evaluation of Claimants' Self-Reported Symptoms in Adjudication of Social Security Disability Claims

Dear Chairman Verkuil:

On behalf of the American Bar Association, which has nearly 400,000 members, I am writing with regard to your Questionnaire concerning the above-referenced study that the Administrative Conference of the United States (ACUS) is conducting on the Social Security Administration's (SSA's) current process for evaluating claimants' symptoms, including pain. Although the ABA does not have specific policy on many of the detailed questions posed by the Questionnaire, we offer the following comments regarding the general process that should be followed in any fact finding, including those involving a SSA disability claimant's symptoms.

The ABA has a longstanding interest in the SSA's disability benefits decision-making process, and we have worked actively for over two decades to protect the adjudicative independence of the administrative judiciary and promote increased efficiency and fairness in the system. As the national voice of the legal profession, the ABA has been able to draw upon the considerable expertise of our diverse membership—including many claimant representatives, administrative law judges (ALJs), academicians and agency staff who are active in the ABA—to develop a wide-ranging body of recommendations on the administrative adjudication process.

Vast numbers of Americans are involved in administrative adjudicative proceedings every day, and the decisions rendered by ALJs in these proceedings often affect their lives in profound ways. Congress recognized the unique function of the administrative law judge when it passed the Administrative Procedure Act (APA), which established the adjudicative independence of the administrative judiciary. The ALJ should be the impartial fact finder in administrative proceedings, and agency policies and procedural rules that affect the public should be published in the Code of Federal Regulations in accordance with the APA.

While the determination of the role and degree of pain in an administrative disability proceeding has its unique challenges, it is a fact finding challenge like that found in many civil adjudications in every type of forum. As the U.S. Supreme Court has stated on several occasions, ALJs are the "functional equivalent of district court judges."

The courts have recognized there are at least three broad public policy interests to be considered in due process hearings with respect to entitlements: the desire for accuracy, the need for accountability, and the necessity for a decision-making procedure perceived as fair. *Gray Panther v. Schweiker*, 652 F.2d 146 (D.C. Cir. 1980). Only in an on the record hearing, before an impartial administrative law judge who can assert authority for development of the record, can a claimant be assured that he or she is receiving a fair decision based upon the facts and the law.

In a due process hearing the ALJ, as independent fact finder, must determine based on the record that the claimant has an impairment which reasonably can be expected to cause pain. There is no known exact test to measure the degree of pain. The evaluation of pain involves the evaluation of facts, medical science and the credibility of the claimant. The ALJ should evaluate the complaints of pain and determine their level of reasonableness using the law and regulations that provide a framework in which this should be done.

Only by providing the claimants with a fair, impartial, and independent ALJ who follows the law and regulations, as provided in the APA, can the claimants be assured that they are receiving a decision that is based on a transparent and fair process as intended by the applicable laws and regulations.

Thank you for the opportunity to express our views on this subject. If you would like to discuss the ABA's views in greater detail, please feel free to contact me at (202) 662-1965 or Hon. Jodi B. Levine, Co-Chair of the Benefits Committee of the ABA Section of Administrative Law and Regulatory Practice, at (866) 701-8094.

Sincerely,

Thomas M. Susman

cc: The Honorable Joe D. Whitley, Chair, ABA Section of Administrative Law and Regulatory Practice

The Honorable Bruce T. Cooper, Chair, ABA Judicial Division National Conference of the Administrative Law Judiciary

The Honorable Jodi B. Levine, Co-Chair, Benefits Committee, ABA Section of Administrative Law and Regulatory Practice

Thomas D. Sutton, Co-Chair, Benefits Committee, ABA Section of Administrative Law and Regulatory Practice

The Honorable Thomas W. Snook, Co-Chair, Federal Administration Adjudication Committee, ABA Judicial Division National Conference of the Administrative Law Judiciary

Response
of the
National Association of Disability Representatives
to the
ACUS Symptom Evaluation Questionnaire
June 9, 2014

1. **What is National Association of Disability Representatives' position on SSA's current regulations for evaluating the credibility of a claimant's statements about his or her symptoms, including pain ("symptom evaluation regulations")? Evaluation of Symptoms, Including Pain, 56 Fed. Reg. 57,928 (adopted November 14, 1991) (codified at 20 C.F.R. §§ 404.1529, 416.929).** http://www.ssa.gov/OP_Home/cfr20/404/404-1529.htm

   404.1529 identifies that **"**We will consider all of your statements about your symptoms, such as pain, and any description you, your treating source or non-treating source, or other persons may provide about how the symptoms affect your activities of daily living and your ability to work. However, statements about your pain or other symptoms will not alone establish that you are disabled; there must be medical signs and laboratory findings which show that you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings and statements about how your symptoms affect you. (Section 404.1527 explains how we consider opinions of your treating source and other medical opinions on the existence and severity of your symptoms, such as pain.) We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work."

   - The current Regulations and Rulings discuss how an ALJ should evaluate pain, but they do not explicitly require specific findings.

   - We find that this section, including "Consider", is not being followed and that most allegations of pain are routinely ignored. Decision makers in the disability process use boiler plate language to categorically discredit allegations of pain. There is also a severe problem with D.D.S. decision makers routinely discrediting a claimant's allegation of pain when the decision makers at this point have not seen the claimant and usually have never even spoken to them. Pain is individualized and similar medical findings do not produce equal levels of pain or limitation in each person.

2. **What is National Association of Disability Representatives' position on SSA's current sub-regulatory guidance for evaluating the credibility of a claimant's statements about his or her symptoms, including pain ("symptom evaluation guidance")? SSR 96-7p, 61 Fed. Reg. 34,483 (July 2, 1996).** http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR96-07-di-01.html

   SSR 96-7p directs that,"Because symptoms, such as pain, sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, the adjudicator must carefully consider the individual's statements about symptoms with the rest of the relevant evidence in the case record in reaching a conclusion about the credibility of the individual's statements if a disability determination or decision that is fully favorable to the individual cannot be made solely on the basis of objective medical evidence.

   "In determining the credibility of the individual's statements, the adjudicator must consider the entire case record, including the objective medical evidence, the individual's own statements about symptoms, statements and other information provided by treating or examining physicians or psychologists and other persons about the symptoms and how they affect the individual, and any other relevant evidence in the case record. An individual's statements about the intensity and persistence of pain or other symptoms or about the effect the symptoms have on his or her ability to work may not be disregarded solely because they are not substantiated by objective medical evidence."

   NADR members find that SSR 96-7p is not being followed. Once again, the decision makers do not see the claimant and allegations of pain limits made by claimants or their witnesses are categorically discredited.

   - NADR members' experience is that ALJ's make credibility findings using popular boilerplate language, thereby concluding that the claimant is not entirely credible. In making their findings, they may say that the claimant has pain but it is not disabling; however, more often than not, that judges do not even mention pain in their Decisions.

   - An ALJ cannot make credibility decisions concerning pain without first identifying the claimant's statements about pain and what their medical records say about their pain. Further, the ALJ must make specific findings concerning what amount of pain they think the claimant has, including specific findings concerning the intensity, frequency and duration of the pain, and then compare the two sets of findings. This is not happening.

3. **What suggestions does National Association of Disability Representatives have, if any, for improving SSA's current symptom evaluation regulations and/or guidance?**

- SSA should send pain questionnaires to each applicant that has a disability that could generate pain.

- SSA should consider adding a pain question to the initial application process that would cue an evaluation of pain if warranted.

- SSA should not routinely discredit allegations of pain as they do not see the claimant and cannot reasonably judge a person's pain level.

- SSA should not routinely discredit the statement of family and friends who provide witness statements regarding the claimant's allegations.

- While the regulations do allow for 20 minute musculoskeletal and neurological consultative exams, NADR believes it is highly unlikely that a proper consultative exam can be conducted in 20 minutes and contain a meaningful report concerning a claimants symptoms, including pain.

- Give credibility to Psychological evaluations that identify pain behaviors.

- DDS should consider amending its "Pain Questionnaire" to include questions about how pain affects the claimant's concentration, if it requires them to change positions and how it affects their sleep. It could also address how their pain affects them in being able to perform tasks in a timely manner and how many days per month they would have to call in sick to a job or leave work early due to pain. A copy of the current Pain Report used by DDS is included as an attachment to the transmitting email for this document.

- A major tool in SSA's evaluation is the Function Report. It is felt that this report is constructed in a way that encourages people to give answers Social Security will later use against them. We recommend that the form be replaced or amended to provide a more accurate picture of how the claimant functions.

- Medical evidence of multiple spinal surgeries (three or more at the same or contiguous levels) over relatively brief periods of time with ongoing treatment and intervening complaints of pain should be considered a listings-level impairment.

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

    - Claimants and their witnesses are not being given due process in this area. Improper credibility determinations are the standard for allegations of pain and their limits by all level of SSA decision-making.

- Allegations of pain are identified in several rulings to have a greater severity than the medical records suggest, however this is rarely the case in decisions.

- Unless a claimant is receiving pain-management treatment, allegations of pain limits are categorically ignored or discredited. Many disability claimants are indigent, uninsured or underinsured and therefore have little or no access to such treatment.

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

   - Lay person statements.

   - Give realistic scenarios for ALJs to consider when evaluating pain. Because someone goes out to eat, vacuums a small apartment, or does their own laundry does not mean that they do not have debilitating pain. For example: If a claimant has migraines, carpal tunnel syndrome and a herniated disc at L4-5, they will experience three distinct types of pain in three different locations. The ALJ must be required to make specific findings, saying either that in each location the claimant has no pain at all, or in each location the claimant does have pain, indicate the severity, frequency and duration of the pain when it occurs. In this example, if the migraines occur four times a week with pain at a 9 on a level of 10 for four hours that subsides to a level of 3 or 4 for a couple of hours and then goes away, the claimant would be unable to work for four days a week and be disabled. The ALJ will typically find the claimant was not entirely credible and therefore not disabled. Or, the ALJ could find the claimant not entirely credible regarding the frequency of the migraines and therefore not disabled, or determine that the pain level is not as high as stated. In such cases, the ALJ would be correct in concluding that the claimant is not entirely credible, but the ALJ would still have to find the claimant is disabled. However, by not making specific findings the ALJ can deny a claim without addressing pain. The current Regulations and Rulings discuss how an ALJ should evaluate pain, but they do not explicitly require specific findings.

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

   - Established rules provide a solid framework for evaluating pain. However, the corporate culture towards clients' allegations of pain within D.D.S.'s across the country is unrealistic and allegations of pain are routinely discredited.

- NADR recommends that forms either be amended or created and used at the Initial and Reconsideration Levels to evaluate pain. Statements from relatives, lay persons, etc. should be used. At the ALJ level, more and more judges are not wanting or even taking testimony outside the Claimant and the medical evidence. However, everyone does not have access to healthcare and therefore, such statements are crucial and necessary from persons who have first-hand knowledge of claimant's allegations of pain.

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

- As previously stated, while there could definitely be room to correct/update the Pain Report/Function Report and indicators for the field office regarding pain alleged by the Claimant either in the office or on the online applications, current policy on evaluating pain should be followed and not just ignored or have boilerplate language put in a Decision. Pain is rarely addressed in initial or reconsideration Decisions. This needs to be changed and addressed.

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

- Enforce current rulings.

- Give credibility to Psychological Evaluations that identify pain behaviors.

- Investigate the Physical Consultative Evaluations being conducted; SSA is simply not getting their money's worth out of this program.

- Evaluate more thoroughly decision's regarding credibility denials based on allegations of pain.

- Amend/update the Pain Report/Function Report to get a better picture of claimant's pain.

- Make more comparisons to the allegation of pain and the medical evidence. There is medical evidence available on symptoms and possible pain. All of these factors should be used in assessing credibility. We realize that there is some subjectivity in allegations concerning pain, but in the example given above regarding migraines, it reasonable per medical studies that a migraine could reach a level of 9 four days a week.

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

Yes, in order to achieve the desired evaluation of pain, we believe the following are necessary:

- Conduct pain management training at the annual conference by pain management and rehabilitation specialists not SSA employees.

- Require credibility denials regarding pain allegations to be identified and supported. Disallow boilerplate language on pain and credibility denials.

- DI 22510.011 "Use of Pain Specialists and/or Pain Centers (Clinics) As CE Sources" provides a procedures on how and when CE's are to be requested, including that the treating physician should be the first contact in requesting a CE. However, this rarely happens in practice. It also provides guidance about when a CE for evaluation of pain is <u>not</u> necessary, i.e. testimony of the claimant and/or their witnesses when the pain is reasonably expected in accordance with the underlying impairment. It is noteworthy that a CE for pain should be requested when the pain is a deciding factor in establishing disability. More guidance is needed about when a CE for pain is or is not warranted. This section of POMS is considered to be more subjective and further supports the need for more training to be provided to SSA employees to better understand chronic pain and its symptoms.

NOTE: This DDS pain questionnaire was included by NADR in response to the Office of the Chairman's questionnaire. SSA does not have a federal pain questionnaire. This pain questionnaire would be used only by the state that developed it.

PAIN REPORT – ADULT

SECTION 1 – IDENTIFYING INFORMATION

1. A. Print **YOUR NAME** *(if different from above)* and **RELATIONSHIP** if completing for claimant:

FIRST ☐☐☐☐☐☐☐☐☐☐ MIDDLE INITIAL ☐ LAST ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Relationship: ______________________

B. Your **SOCIAL SECURITY NUMBER** *(if different from above)*:

☐☐☐ - ☐☐ - ☐☐☐☐

C. Your **MAILING ADDRESS** *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*:

CITY	STATE	ZIP CODE

D. **DAYTIME TELEPHONE NUMBER** (if there is no telephone number where you can be reached, give us a daytime number where a message can be left for you):

Area Code ☐☐☐ Number ☐☐☐ - ☐☐☐☐

PAIN DESCRIPTION

Please answer the questions on the following pages concerning the pain related to your illnesses or injuries. If you have pain in more than one part of your body (for example, chest pain and headache), please describe each one separately. Use Section 2 for the first pain, Section 3 for the second pain, and so on. If you have pain in more than three parts of your body, use Section 5, REMARKS, to describe the other pains.

SECTION 2 – FIRST PAIN

2. A. Where do you have the pain? *For example, lower back, top of head, right hip, etc.*

____

____

B. What kind(s) of pain do you have?

☐ Aching ☐ Burning ☐ Cramping ☐ Crushing

☐ Stabbing ☐ Stinging ☐ Throbbing ☐ Other Specify:

____

C. How often do you have this pain?

_______________ per
Number of times

☐ Minute ☐ Day ☐ Month

☐ Hour ☐ Week ☐ Year

OR ☐ Continuously

D. How long does this pain generally last? *Try to answer in terms of length of time you have pain without stopping; for example, 30 minutes, 2 hours, all day, etc.*

____

____

E. How bad is this pain? *Be specific; describe in your own words any ways that your pain stops you from working, from doing things around the house, or from doing anything else you could do before the pain started.*

____

____

____

F. What causes this pain or makes it worse?

____

____

____

2. G. What relieves this pain or makes it better?

H. If you take any medicine(s) (prescription or non-prescription) for this pain, please complete the following:

Name of Medicine? *(for example, CODEINE)*	Date You Began Taking it *(for example, 12/06/91)*	Dosage *(for example, 1-2 pills)*	How Often Taken? *(for example, every 4 HOURS)*	Relieves the pain?
	Month ☐☐ Day ☐☐ Year ☐☐			☐ Always ☐ Sometimes ☐ Never
	Month ☐☐ Day ☐☐ Year ☐☐			☐ Always ☐ Sometimes ☐ Never
	Month ☐☐ Day ☐☐ Year ☐☐			☐ Always ☐ Sometimes ☐ Never

I. Does the medication cause any side effects? ☐ **YES** ☐ **NO**
If "yes," please explain:

2\. G. What relieves this pain or makes it better?

H. If you take any medicine(s) (prescription or non-prescription) for this pain, please complete the following:

Name of Medicine? *(for example, CODEINE)*	**Date You Began Taking it** *(for example, 12/06/91)*	**Dosage** *(for example, 1-2 pills)*	**How Often Taken?** *(for example, every 4 HOURS)*	**Relieves the pain?**
	Month ☐☐ Day ☐☐ Year ☐☐			☐ Always ☐ Sometimes ☐ Never
	Month ☐☐ Day ☐☐ Year ☐☐			☐ Always ☐ Sometimes ☐ Never
	Month ☐☐ Day ☐☐ Year ☐☐			☐ Always ☐ Sometimes ☐ Never

I. Does the medication cause any side effects? ☐ **YES** ☐ **NO**
If "yes," please explain:

4. G. What relieves this pain or makes it better?

____

____

____

H. If you take any medicine(s) (prescription or non-prescription) for this pain, please complete the following:

Name of Medicine? *(for example, CODEINE)*	**Date You Began Taking it** *(for example, 12/06/91)*	**Dosage** *(for example, 1-2 pills)*	**How Often Taken?** *(for example, every 4 HOURS)*	**Relieves the pain?**
	Month ☐☐ Day ☐☐ Year ☐☐			☐ Always ☐ Sometimes ☐ Never
	Month ☐☐ Day ☐☐ Year ☐☐			☐ Always ☐ Sometimes ☐ Never
	Month ☐☐ Day ☐☐ Year ☐☐			☐ Always ☐ Sometimes ☐ Never

I. Does the medication cause any side effects? ☐ **YES** ☐ **NO**
If "yes," please explain:

____

____

____

____

NATIONAL ORGANIZATION OF
SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES
(NOSSCR)

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June 9, 2014

Stephanie J. Tatham
ACUS Attorney Advisor
Administrative Conference of the United States
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Washington, DC 20036

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

Dear Ms. Tatham:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The preface to the final rule explains:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

* * *

Thank you for asking us to provide these comments.

Very truly yours,

Cynthia Berger
President, Board of Directors, NOSSCR

Barbara Silverstone
Executive Director, NOSSCR

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November 4, 2014

Ms. Stephanie Tathum
Staff Counsel to the Committee on Judicial Review
Administrative Conference of the United States
1120 20th Street, NW
Suite 706 South
Washington, D.C. 20036

Dear Ms. Tathum

The National Association of Disability Examiners (NADE) is in receipt of the ACUS Symptom Evaluation questionnaire. This document indicates the Administrative Conference of the United States (ACUS) is conducting a study to review and analyze the Social Security Administration's (SSA's) laws, regulations, policies and practices concerning the evaluation of claimant's self-reported symptoms in the adjudication of social security disability claims. We are happy to provide the following response to the questions contained therein:

1. **What is the National Association of Disability Examiners' (NADE's) position on SSA's current regulations for evaluating the credibility of a claimant's statements about his or her symptoms, including pain ("symptom evaluation regulations")? Evaluation of Symptoms, Including Pain, 56 Fed. Reg. 57,928 (adopted November 14, 1991) (codified at 20 C.F.R. §§ 404.1529, 416.929).**

   NADE believes that SSA's current regulations for evaluating the credibility of a claimant's statements about his or her symptoms, including pain is appropriate.

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

NADE believes that the guidance for evaluating the credibility of a claimant's statements about his or her symptoms, including pain is appropriate. It is a challenging issue for adjudicators to address, considering the degree of subjectivity that is usually involved. The guidance does provide the tools for adjudicators to make a fair assessment.

3. **What suggestions does NADE have, if any, for improving SSA's current symptom evaluation regulations and/or guidance?**

   NADE suggests the Electronic Claims Analysis Tool (ECAT) should be modified so that it can be optimally utilized as a tool to address the credibility of a claimant's statement. Since the issue of credibility is to be considered in assessing the claimant's condition once there is a Medically Determinable Impairment (MDI), we believe it would be better to have the credibility section to be located immediately following the MDI and prior to the medical disposition section. A revision in ECAT of the symptoms and credibility page would also help avoid any potential confusion by the adjudicator. Due to the current logical pathing of ECAT in the symptoms and credibility section, the adjudicator must answer questions correctly to consider all the factors and assess the credibility of the individual's statements. We believe there would be less confusion if all the questions were available on the page without having to answer the other questions.

4. **What legal or practical concerns does NADE have, if any, regarding the symptom evaluation regulations and/or guidance as applied within the SSA adjudicatory process and as reviewed by the federal courts?**

   NADE finds that, although the policy is appropriate, in practice there are challenges in addressing statement credibility. Some claims are more complex and need additional information for adjudicators to accurately assess the statements for credibility. There is often a somatization factor in pain that can be challenging to determine the medical disposition. Sometimes additional clarification can make a difference in the outcome of the claim. An issue at times is that statements on the SSA forms, namely the SSA-3368 and the SSA-3373 are vague or misleading. Ideally, the adjudicator will contact the claimant in these situations for the purpose of obtaining additional information and/or clarification from the individual or a valid third party contact. This sometimes does not happen because of the time required to do so. Many adjudicators are under high production demands and additional adjudicative steps that require extra time are sometimes avoided if the adjudicator believes the extra time spent on the case will not change the decision on the case but only provide corroboration of the determination. NADE suggests there should be consideration of the impact on the workload of adjudicators when addressing the credibility of an individual's statement on every case.

5. **What factors would NADE suggest that the SSA disability determination process take into account in evaluating a claimant's statements about his or her symptoms, including pain?**

NADE finds it important when considering Activities of Daily Living (ADL) to consider the consistency and sustainability of the ADLs as provided by the claimant and any third parties. If available, the observations of SSA Field Office Personnel should also be considered in assessing the credibility of the claimant.

6. **What findings, if any, would NADE suggest that adjudicators make in evaluating a claimant's statements about his or her symptoms, including pain? What type of support should underlie such findings?**

   NADE suggests that the adjudicator consider if symptoms, such as pain have an impact on an individual's functioning. We believe that a thorough review of the claim file will provide adequate findings in most cases to provide a strong basis for addressing the credibility of the claimant. Statements submitted by the claimant regarding his or her symptoms will, in most cases, be supported or refuted by the statements submitted by third parties, medication lists, SSA Field Office observations, observations reported by the treating physician or other examining physician, etc.

7. **Does NADE have any additional comments or views it would like to share on the SSA's current process for evaluating a claimant's statements about his or her symptoms, including pain?**

   NADE would like to reiterate that appropriately assessing claimant credibility and pain considerations can be time consuming. To make an appropriate assessment that is fully supported by the evidence in the claim file, we believe adequate time should be allotted for adjudicators to consider all the factors present in the case and for adjudicators to undertake additional case development actions to resolve questions if and when they arise. With many adjudicators experiencing increased workload demands, this is not always possible and the assessment of claimant credibility may not be given the due consideration it deserves.

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

   NADE would like to suggest SSA's policy on acceptable medical sources in determining if a Medically Determinable Impairment (MDI) exists should be reconsidered. For the disability adjudicators in the DDSs, this policy is defined in POMS DI 22505.003 B.1. NADE would like to point out there is a growing population of disability applicants that receive their medical treatment from sources who are not considered "acceptable" for disability determination purposes. This list of such sources includes physician assistants and nurse practitioners. While evidence from these sources can be used in the adjudication of the claim, it cannot be the sole basis of establishing the presence of a MDI. NADE would suggest there should be a stronger focus on the totality of the

evidence, with consideration of the specialty and licensure of the treating source, rather than applying a strict definition of a limited number of acceptable medical sources.

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

   NADE believes there is a much better understanding and consideration of the impact of pain in a condition. However, the issue has become more complicated with the growing problem of narcotic abuse and/or abuse of prescribed medications. Such abuse can lead to manipulation within the healthcare system and often has the result of decreasing the pain tolerance of such claimants. Overall, the changes in policy that have been made regarding how adjudicators should approach the evaluation of acute and chronic pain have provided positive tools to be utilized by the adjudicators and have been a tremendous asset. Even so, the overall impact of these policy changes appear to have been made without regard for the additional time required to process disability claims in accordance with the new regulations.

In conclusion, NADE is appreciative of the opportunity to provide input on this issue. We hope our response addresses your questions but if we have missed something, please do not hesitate to contact us. NADE is deeply committed to the concept that SSA's policies and regulations should ensure all claimants to fair and timely decisions on their claims for disability benefits but should also ensure that disability adjudicators have the tools, the knowledge and the time to apply the policies and regulations in the manner they were intended.

Sincerely,

Jeffrey H. Price

Jeffrey H. Price, NADE President

Stephanie Tatham

Subject: Re: ACUS Symptom Evaluation questionnaire
Attachments: lyon_hart_testimony32013.pdf; NCDDD Response to QFR for HWM SSS 05-2013.pdf

Dear Ms. Tatham:

Thank you, and thanks to ACUS, for your interest in obtaining input from the National Council of Disability Determination Directors (NCDDD). NCDDD is a nonprofit organization composed of Disability Determination Services (DDS) Directors and management staff. Our purpose is to provide the highest possible level of service to people with disabilities and to encourage policies that best serve the public interest in accomplishing the mission of the disability program. We work towards these goals through education, partnership and consultation among the DDSs and between the DDSs and the Social Security Administration. As a nonprofit under Section 501(c)(3), we do not advocate for any specific policy agenda. As an organization of DDS managers, we carry out the policies to the best of our ability and keep policy makers informed of operational realities, issues and concerns.

The best response I can give to your questionnaire in the time allotted is to share with you my testimony on behalf of NCDDD in March 2013 to the House of Representatives, Committee on Ways and Means, Subcommittee on Social Security. It addresses most of the issues raised in your questionnaire in as much detail as I can provide on behalf of NCDDD as an organization. I have also included the answers I provided the subcommittee to subsequent questions for the record. Answers to questions 1 and 5 are most relevant, although there may be other relevant pieces in some of the other questions. Please see the attached documents.

Thank you again for requesting our input. We look forward to reading your final report.

Trudy

Trudy Lyon-Hart

President, National Council of Disability Determination Directors

Director, Disability Determination Services

Department for Children and Families

Agency of Human Services

State of Vermont

TESTIMONY OF

TRUDY LYON-HART, PRESIDENT

NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS

to the

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS

UNITED STATES HOUSE OF REPRESENTATIVES

March 20, 2013

Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee:
Thank you for the opportunity to testify on behalf of the National Council of Disability Determination Directors (NCDDD) to provide information on Social Security Disability Program policy and the challenges in its application in disability determination. NCDDD is a professional association composed of the Directors and managers of the Disability Determination Services (DDS) agencies located in each state and the District of Columbia. NCDDD's members direct the work of approximately 15,000 employees. Annually we process over 4.8 million cases, including initial claims, continuing disability reviews, and reconsideration-level appeals.

NCDDD's goals focus on providing consistent, fair, accurate, timely, and cost-efficient decisions. The DDS community works in partnership with the Social Security Administration (SSA) to provide high quality public service to individuals applying for disability benefits, and to help ensure the integrity of the disability program.

The Social Security disability criteria are very strict by design. In recent years, the DDSs have allowed 33-36% of initial claims, and 11-14% of the reconsideration-level appeals. However, the DDS allowances make up the vast majority of the allowances overall – last year, for example, the DDSs cleared 1,014,601 initial and 92,601 reconsideration allowances. In any given year, over 70% of applicants who receive a favorable disability determination receive it from the DDS, at the initial or reconsideration level, without a long wait for a decision by an Administrative Law Judge.

Both our allowance and denial determinations are very accurate. By statute, SSA reviews 50% of the allowances before the decisions are effectuated, and the DDS "PER" (pre-effectuation review) error rate has been under 3% for the past 5 years. SSA also performs a quality review sample of both allowances and denials, and the DDS net accuracy rate has been 97% or better over the last 3 years.

The DDSs also process medical Continuing Disability Reviews (CDRs) under the Medical Improvement Review Standard (MIRS). The MIRS policy protects people from being taken off the rolls without proof that

their medical condition has significantly improved. Despite a very low cessation rate under this policy, processing medical CDRs results in $9-10 of program savings for every administrative dollar spent.

The DDSs face serious challenges in maintaining high quality service and program stewardship, as greater numbers apply for benefits while a hiring freeze continues for a third fiscal year. Occasionally SSA has been able to fund a small amount of DDS replacement hiring. However, the DDSs do not recover lost capacity for two more years – the time it takes to train a new adjudicator. Without sufficient funds for advance hiring and adjudicator training, the DDSs have great difficulty processing additional stewardship workloads such as CDRs.

Initial and reconsideration cases are already sitting without being worked for months in many DDSs. As of March 8, 2013, nearly 19% of the pending initial cases and 34% of the reconsiderations (totaling almost 190,000 cases) were backlogged awaiting assignment to an adjudicator. Balancing inadequate resources between the initial/reconsideration and the CDR workloads is increasingly detrimental to both customer service and program integrity. In some states, initial and reconsideration cases may have priority over CDR completion since initial applicants have not had the opportunity to receive critical benefits and associated health care.

Budget cuts and shortfalls present challenges across all of government. Under tight regulatory and budget oversight, the DDSs historically have kept expenditures mission-critical and cost-effective. We regularly give high quality service, productivity, and return on investment for the funding we receive. We request Congress provide the funding necessary for us to serve the vulnerable population of people with disabilities and to carry out the number of CDRs necessary to bring program stewardship up to date in a carefully planned, strategic way. Along with this administrative funding, we recommend certain policy challenges be examined and where appropriate changed to improve decision-making and preserve the integrity of this important program for the future.

The following testimony provides an overview of disability evaluation and discusses specific policy areas that are problematic in their complexity and potential for inconsistency in decision-making.

Overview of Disability Evaluation for Social Security

The DDSs make complex medical determinations for the Social Security disability program in accordance with Federal law, regulations, Social Security rulings and policy guidance. The statutory definition of disability for adults is the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) that can be expected to result in death or to last for a continuous period of at least 12 months. A medically determinable impairment must be documented by medical evidence including relevant clinical signs, symptoms and laboratory findings. While individuals provide a list of their medical providers when they apply, the DDS does the work of obtaining the medical reports and records, ordering

additional examinations or tests if needed, and obtaining sufficiently detailed reports to cover the individual's impairments according to Social Security's evidentiary requirements for disability evaluation.

In deciding claims, the DDS follows the sequential evaluation policy in the *Code of Federal Regulations*. For adult claims, this involves consecutively assessing current work activity, the severity of the impairment(s), whether the impairment meets or equals those described in the *Listing of Impairments*, the residual functional capacity for past work and finally the capacity for other work in the national economy, considering age, education and work experience. The first three steps help streamline the process and conserve administrative resources for the most difficult areas of evaluation. The first two rule out people who are currently performing substantial gainful activity or who have no medically determinable impairment imposing any significant work-related limitations. The third step – determining Listing-level severity – helps us award benefits quickly to those with exceptionally severe impairments.

The *Listing of Impairments* describes medical conditions that are considered severe enough to prevent any gainful activity. Most of the entries are not based solely on diagnosis but also require specific medical findings and associated functional limitations demonstrating great severity. These impairments are generally permanent, expected to be of lengthy duration, or cause death. Examples include terminal cancers, ALS, amputation of two hands, strokes resulting in permanent loss of use of two limbs, and chronic schizophrenia with repeated, extended episodes of decompensation.

The fourth and fifth steps of sequential evaluation require a full medical/functional/vocational assessment that is much more labor-intensive than the previous steps. The DDS must make findings of fact about the individual's remaining capacity to perform and sustain a detailed set of work-related functions, physical and mental, such as lifting, carrying, walking, standing, sitting, stooping, use of hands and arms, understanding, remembering, concentrating, persisting on task, interacting with people, and handling changes. This Residual Functional Capacity (RFC) assessment also includes the ability to work around various environmental challenges such as dust, fumes, hazards, and extreme temperatures. The RFC is derived from an in depth analysis of the medical and functional information the DDS has obtained from healthcare records, medical, psychological or other types of evaluations, and the statements of the applicant and other knowledgeable sources. RFC assessment must consider the impact of the individual's symptoms on function, the credibility of the individual's statements, and the amount of weight to give to medical source opinions.

Once RFC is established, the DDS must determine whether the individual has the capacity to perform any past relevant work performed within the prior 15-year period, either as the person performed it, or as usually performed in the national economy. If the individual cannot do any past work, then the DDS must determine

whether there are other jobs existing in the national economy that the person can perform, considering age, education and past work experience.

Policy Areas of Particular Complexity

Determining whether someone can or cannot work by nature involves more than just objective medical findings. The same diagnosis and the same or similar clinical findings may affect one person quite differently than another in their functional capacity for work, for many reasons. Accurate disability determination is not an exact science. It involves adjudicative judgments, and in Social Security disability many of the policies to be applied are often very detailed and complex. Three policy areas are particularly challenging. They are the core of disability evaluation for those individuals whose impairments are not clearly disabling on a purely objective medical basis.

1. Symptoms and Credibility

   The evaluation of pain and other symptoms and their limiting effects starts with determining whether the person has a medically determinable impairment that could cause the symptoms. Once the related impairment is established, the DDS must evaluate the intensity, persistence and functional limitations affecting basic work activities, based on descriptions provided by the applicant, the medical reports, and any other reports or observations. The assessment includes considering the credibility of the person's statements and determining the appropriate weight to give them. The policy directs consideration of various factors: description of symptom location, duration, frequency, and intensity; precipitating or aggravating factors; impact on daily activities; medications, treatments, and other measures to relieve the symptoms, their effectiveness, and any side effects. Credibility assessment is not a "gut feeling" about the person's overall truthfulness, but rather an evaluation of the consistency of the statements throughout the record and the support for them in the medical findings and other information in the file. However, we cannot disregard an individual's statements solely because the objective medical evidence does not substantiate them. While the policy provides guidance and lists the factors to consider in symptom evaluation, in the end there is no way to measure conclusively symptom severity and credibility. The adjudicator is expected to draw reasonable conclusions based on the evidence in each individual case.

2. Medical Source Opinion

   The policy requires adjudicators consider all medical source opinions, (i.e. statements about the nature and severity of the impairment/s). Different medical sources may have different observations and opinions. Controlling weight must be given to <u>treating</u> source opinions that are well supported by

objective medical evidence and not inconsistent with other substantial evidence in the file. Controlling weight should not be given to opinion without substantiation or supporting objective findings. When controlling weight is ruled out, the opinion must still be considered and weighed. Factors the policy directs us to consider include the relationship between the source and the claimant, the source's specialty, the value of the supporting evidence, and the consistency of the opinion with other evidence in the file. There is no exact formula for the relative weighing of all these factors. It can be very complicated to sort out all the opinions and facts that tend to support or contradict them, and then it can be very challenging to decide and explain the appropriate weight for each. Different adjudicators can legitimately weigh all these factors differently and come to different conclusions.

3. Residual Functional Capacity (RFC) and Sustainability

   The RFC is the administrative assessment of what work-related functions the individual can do (physically and mentally). It is based on all the evidence, including the objective medical findings, the individual's statements about limitations (to the degree the adjudicator has found them credible) and the opinion evidence (to the degree of weight the adjudicator has assigned each opinion based on how much it is supported by and consistent with the rest of the evidence). The RFC should reflect the most that a person can do on a sustained basis over time. It is particularly difficult to assess applicants who have fluctuating levels of pain or fatigue, or other symptoms that wax and wane in a variable way.

These are the most difficult judgment areas, where different adjudicators may interpret and apply the policies differently in individual cases. These are also the areas where the information being evaluated is subjective by nature, coming from applicant self-reports and opinions from different sources with different perspectives. The subjectivity of these decisions does not mean that adjudicators can decide cases based on their personal beliefs and assumptions about the claimant's impairment severity. The policies clearly direct the adjudicator to consider specific factors, and they provide some guidance about how to assign weight. What the policies do not – and cannot – do is provide a formula that directs a specific decision in an individual case. These case evaluations call for careful attention to detail and thoughtful analysis of all the information in the case file, as well as knowledge of the functional ramifications of medical findings.

SSA and the DDSs maintain programs to teach this type of decision-making, and the DDSs do an excellent job achieving sustained high accuracy of their decisions, despite the ambiguity of the policy, and the challenges of high workload, insufficient staffing, and continued loss of experienced staff. Although individual case decisions are generally found to be accurate, achieving consistency all across the country and at all appeal levels, especially in these areas of subjective decision-making, is a continuous improvement project.

The DDSs work collaboratively with SSA to improve consistency. All DDSs provide intensive training and mentoring to new adjudicators, as well as ongoing mentoring and refresher training. SSA and DDSs are working together to make the best training resources readily available to all DDSs across the nation, through organization and continual updating of online resources, video on demand training sessions, national policy dialogues and refreshers, online training case examples, and web-based state-to-state sharing of training materials. Information technology tools such as the electronic claims analysis tool (eCAT) also help to standardize the way DDS adjudicators think through the evaluation process and explain their decisions in writing. The predictive modeling software that identifies cases that are appropriate for the Quick Disability Decision (QDD) and the Compassionate Allowance (CAL) processes also help to bring consistency to the disability determination process.

Quality reviews and performance management are also important tools. SSA holds DDSs accountable for accuracy, productivity, processing time, and cost control. The DDSs translate these requirements into adjudicator performance requirements. DDSs do internal quality reviews, in addition to the quality reviews SSA performs. SSA's quality reviews are now done nationally, rather than regionally, and there is a centralized process for resolution of policy questions and disagreements. These two practices in combination have the potential over time to greatly improve consistency across all DDSs and SSA quality review offices. The database of cases with policy feedback is also valuable for identifying policy areas that generate the most questions and are particularly problematic, so that SSA can look at ways to improve the policy. The database is also helpful in assessing further training needs, both nationally and for an individual office.

Achieving national consistency is an ongoing process. Continued progress is needed and is dependent upon sufficient resources. High workloads, budgetary challenges and staff losses slow down the progress. Lack of resources to review cases for policy clarification, to analyze data and to develop training impedes progress. In the DDSs, high workloads and loss of experienced staff impedes our ability to carry out an optimal number of quality reviews or pursue quality improvement initiatives.

Although disability evaluation will always involve a certain amount of subjectivity, the policies in these most subjective areas should be reviewed and consideration given to ways they could be made less resource intensive and easier to apply consistently. This is not a simple task. It would not be right or fair to many truly disabled people to completely ignore the opinions of the doctors that know them best or discard consideration of their pain and other symptoms and the way these symptoms limit their personal capacity for work. However, we should explore ways to determine disability that could require fewer resources and yield outcomes with more consistency. This exploration should involve the collaboration of medical and policy experts and experts in the front line challenges of applying policy to individual cases.

Continuing Disability Reviews – the Medical Improvement Review Standard

The Medical Improvement Review Standard (MIRS) was developed in the mid-1980s in response to public outcry over the implementation of continuing disability reviews (CDRs) that led to many people being removed from the rolls in a problematic way. Many of these people had been on the rolls and out of the workforce for a great many years. They had been granted benefits before the establishment of the strict criteria (particularly for mental impairments) in place in the early 1980s. The CDR reviews of the early 1980s applied the strict current criteria and did not consider the impact of advancing age and many years in supportive living situations out of the workforce. Many of the people losing their benefits had no ability to cope or adapt. In 1983, a moratorium was placed on CDR processing, and in 1984, the medical improvement requirement became law.

The MIRS requires us to determine whether any of the beneficiary's impairments present at the last favorable determination have improved, and if so, whether the improvement is related to the ability to work and whether the person now has the capacity to work. Improvement must be based on changes in symptoms, signs, and/or laboratory findings, resulting in increased work-related functional capacity such that the person can now engage in substantial gainful work. In assessing current ability to work, we consider all current impairments, not just the ones present in the past. The policy requires that we also consider the effects of the aging process and the related decrease in organ function, exercise ability, and other deficits that become irreversible over time, especially with sustained periods of inactivity. In addition, we must consider the effect of time on the rolls away from the workplace. Age and time on the rolls become especially critical factors when the beneficiary has reached age 50 or older.

The policy includes some narrowly defined exceptions, which open the door to stopping benefits in a few situations even though the person's impairments have not improved, or we cannot make a determination about medical improvement. These exceptions apply when the person's ability to work has improved due to advances in medical or vocational therapy, or when new evaluative techniques show that the impairment is not as disabling as it was thought to be at the time of the previous decision. There are also exceptions for lack of cooperation with the CDR process and for proven fraud. There is an additional exception for situations when substantial evidence shows on its face that the prior allowance was in error. However, the latter can be applied only for obvious, concrete errors; current adjudicators cannot question or substitute their own judgment over the judgment of the adjudicator of the prior favorable decision.

In practice, DDS adjudicators cease benefits in only a small percentage of cases. Given that the criteria require permanent or long-term inability to do any substantial gainful work, it is not surprising that many beneficiaries continue to qualify. Even with cases where benefits were originally granted through adjudicative judgment, the

stricture against substituting judgment at the CDR limits the use of the error exception to cease benefits. In practice, this exception can rarely be applied.

We recommend a review of the statutory and regulatory MIRS policy to consider improvements that would enhance program integrity and bring greater consistency, while doing no harm to beneficiaries who continue to quality. We do not recommend discarding the policy altogether. Some consideration of the real effects of aging and time on the rolls, the impact of chronic impairment on functioning and ability to return to the workforce is reasonable. Due process and careful consideration of all the factors in each beneficiary's case are very important. Decisions about how to redesign the policy to remove the right people who really can work, while doing no harm to those who cannot, must be made very thoughtfully and carefully.

Even within the narrow limits of MIRS, the cessations the DDS makes provide substantial program savings for the investment of administrative dollars. It is unfortunate that SSA and the DDSs have not had sufficient funding to maintain CDR processing so that all cases are reviewed promptly when their diary dates come due. Nor is it appropriate service to American people with disabilities to delay the processing of current claims in favor of processing more CDRs with the available funds. Full funding for both workloads is critical.

Conclusion

The DDSs have a long record of collaboration and accomplishment working with SSA to provide high quality service and careful program stewardship. Together we have made strides in advancing consistency in the application of policy, despite the challenge inherent in deciding who really can and cannot work. There is much more that can be done with sufficient resources for strategic hiring to build and maintain an experienced, highly trained staff. The most challenging policies should be evaluated with careful consideration. NCDDD would like to play a continuing role in such policy evaluation, sharing our ideas and experiences adjudicating cases on the front line and advising on issues of policy application and workability as new policies are considered.

Mr. Chairman, on behalf of NCDDD, I thank you again for the opportunity to provide this testimony. We will be happy to provide any additional information you need and answer any questions you have.

ncddd

NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS

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May 23, 2013

Representative Sam Johnson, Chairman
Attn: Kim Hildred, Staff Director
Subcommittee on Social Security
Committee on Ways and Means
U. S. House of Representatives
B-317 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Johnson,

Thank you again for providing the opportunity for NCDDD to present testimony at the Committee on Ways and Means, Subcommittee on Social Security hearing on March 20, 2013 concerning to the challenges of achieving fair and consistent disability decisions.

The following are my responses to your questions for the record:

1. What training are DDS examiners given to prepare them to assess limitations regarding pain? How do examiners evaluate allegations of pain? Since everyone's threshold for pain is different, does that mean that different examiners could weigh information about pain differently?

Examiner training in assessing limitations regarding pain includes the relevant sections of SSA's standard Disability Examiner Basic Training Package and intensive mentoring and supervision over many months as examiners learn to apply the criteria case by case. Medical consultants are provided program education via SSA's Medical/Psychological Consultant Handbook.

Examiners apply the criteria in Social Security Rulings 96-3p, 4p and 7p, and follow related Social Security policy guidance to evaluate the severity and functional impact of symptoms and the credibility of the claimants' statements regarding these issues. They weigh the evidence, analyze and resolve any apparent contradictions in the all the information, and assess the medical and other evidence that helps to describe the impact on the individual claimant. They obtain input from DDS medical consultants as needed or required.

Whenever subjective information is weighed and analyzed, there is the possibility of different decision makers coming to different conclusions. The policy guidelines are designed to ensure that decision makers consider the same factors and go through the same decision process.

2. On page 7 of your testimony, you discuss the history of the medical improvement review standard, how it works and your recommendation for a review of this standard. During a

continuing disability review, a person's benefits can be stopped if an examiner determines that they have medically improved. At this Subcommittee's March 13, 2013 hearing, we learned that some people are receiving benefits for as many as 12 years on average. If a person was determined to be disabled 12 years ago and their condition has not changed, but they would not qualify for disability benefits under today's standards, what happens? What if the file doesn't have a lot of information in it or somehow gets lost? Can someone be deemed medically improved then?

Generally, if a person's condition has not changed since the last favorable determination, they will be found still disabled under the Medical Improvement Review Standard, even if they would not meet today's standard. There are a few narrowly defined exceptions (see page 7 of my testimony).

If material from the prior file is lost, and the person's current medical condition does not meet the current disability standard, SSA and DDS reconstruct the prior file to the extent possible. If the reconstruction results in adequate evidence to clearly document the basis for the comparison point decision (most recent favorable decision), the DDS applies the medical improvement standard. If a lost folder cannot be adequately reconstructed, SSA policy directs that a favorable current decision must be made [20 CFR §404.1594(c)(3)v].

Electronic disability folders are less apt to be lost. As more time elapses since the advent of SSA's electronic folder system, lost folder situations should become more rare and less problematic.

3. As part of the decision-making process, examiners may be required to determine if a person has the functional ability to do jobs that exist in the national economy. How do examiners determine whether these specific jobs exist in significant numbers in the national economy? Do you have access to experts or do you rely on the outdated Dictionary of Occupational Titles?

As directed by SSA, examiners use the Dictionary of Occupational Titles (DOT) and other guidance provided by SSA in regulations, rulings and the Program Operation Manual System (POMS). Some DDSs have specific employees trained as vocational specialists. These are experts in the Social Security Disability Program's vocational policy.

The DOT has not received a substantive update in many years, and the Department of Labor database that replaced it (O*NET) does not provide sufficient information for the requirements of disability determination. A new Occupational Information System is in planning and development stages with SSA and the Bureau of Labor Statistics. In the meantime, use of the DOT provides greater consistency in decision-making than would exist if each DDS based their vocational assessments on local expert opinions alone. The statutory requirement is the inability to perform occupations in the *national* economy, not whether jobs in these occupations exist in the *local* economy.

4. On page 4 of your testimony, you stated that examiners have to give controlling weight to treating source opinions in certain circumstances. What does "controlling weight" mean?

When a treating source medical opinion is well supported by objective medical evidence and not inconsistent with other substantial evidence, SSA policy directs adjudicators to give it controlling weight. This means that the opinion must be adopted in the disability determination (Social Security Ruling 96-2p). Controlling weight does not apply to legal conclusions such as whether a person's impairment meets or equals the Listings, or whether the person is "disabled" (Social Security Ruling 96-5p).

5. In your testimony you stated that a credibility assessment is not a "gut feeling" about the person's overall truthfulness, but rather an evaluation of whether the medical findings and other evidence support what the person says. Furthermore, you noted that examiners cannot disregard what the person says solely because the objective medical evidence does not substantiate them. What does the finding of credibility come down to?

The finding of credibility comes down to the degree to which a person's statements can be believed and accepted as true based on the degree to which the statements are consistent with the objective medical and other evidence in the record. Credibility is not an all-or-nothing finding: the person's statements may be found partially credible.

6. Can you discuss why, in Fiscal Year 2012, the Puerto Rico DDS awarded benefits 59.1 percent of the time, when the Mississippi DDS awarded benefits 25 percent of the time?

Allowance rates can be affected by many factors, including regional demographic and economic factors. NCDDD does not have knowledge of DDS-specific circumstances and cannot address this question. Please refer this question to SSA.

7. Does Social Security require a claimant to fully complete the application for benefits, or does DDS have to contact the claimant to fill in any gaps in the application? What percentage of applications is complete when they arrive at a DDS, with all information needed to make a decision? What type of information is most often missing?

SSA Field Offices have responsibility for overseeing the application process. NCDDD does not have data to show the percentage of application forms that are/are not completed by the claimant or what information is most often missing. In practice, the need for SSA or DDS to clarify or obtain further information depends on the specifics of the individual claim. For example, detailed vocational information is generally unnecessary if the claimant's condition meets or equals a medical listing.

8. Is the claimant required to bring in medical evidence? How much time does it take an examiner to get all the information needed to make a decision? What percentage of an examiner's time is spent tracking down information, as compared to making a decision about a case? If claimants were required to submit all information, would it speed up the decision making process?

If claimants have copies of their medical evidence, they are encouraged to submit it. Otherwise, DDSs generally obtain the medical evidence. The time it takes to do so varies considerably depending on individual case situations. The proportion of time spent "tracking down information" versus making a decision varies from case to case and from medical source to medical source.

Requiring claimants to obtain and include all their medical evidence with their application would likely extend rather than speed up the claim process. DDSs have business processes and electronic tools that make obtaining medical evidence a very efficient process. Our evidence requests are tailored to what is necessary and pertinent to the disability determination for the specific case, whereas the claimant does not know this and could spend considerable time getting copies of records that have no bearing on the case. Often a claim can be decided *favorably* on one or a few pieces of evidence without waiting for all the evidence to arrive.

Having the DDS obtain the evidence directly from the medical sources also is a good way to protect against potential fraud (filtering or tampering with the evidence).

9. What role does a DDS examiner have in making the initial decision? What role does the doctor have in making the initial decision? What are the qualifications for a disability examiner? Does the level of education required vary by State?

The examiner and the doctor are considered an adjudicative team. The examiner is responsible for the overall disability determination, which requires synthesis of many factors – programmatic, vocational and onset-related as well as medical/functional. The doctor provides input for the assessment of medical severity and/or residual functional capacity. Twenty DDSs operate under the "Single Decision Maker" test regulations; in these DDSs, specially trained "SDM" examiners have the authority to make determinations within certain parameters based on the SDM's programmatic medical expertise with or without consultation with a medical consultant.

Qualifications for DDS examiners are defined by the states that employ them. Different states may have different educational and experience requirements. Most require a Bachelor degree or equivalent. All provide a rigorous training program for new examiners, followed by intensive mentoring and supervision until the examiner has demonstrated the capacity to maintain performance standards for accuracy, timeliness, and productivity.

10. How does Social Security ensure that training for DDS examiners is provided consistently nationwide? What professional development and continuing education opportunities are offered to ensure are examiners have the skills needed to make decisions effectively?

SSA maintains the Disability Examiner Basic Training Package and the Medical/Psychological Consultant Handbook, as well as many other training resources, including video on demand and PowerPoint training presentations, online case studies, national "policy dialogue" conference calls, desk guides, and online indices of policy guidance.

The effectiveness of examiners' decision-making is ensured on the front line through DDS internal quality assurance and performance measurement. Social Security ensures it through federal quality reviews, analysis of the data from these reviews, and development of training and/or clarification of policy based on the results. The electronic case analysis tool (eCAT) also provides examiners and medical consultants a policy-compliant decision guide for each case with links to relevant online policy guidance.

Individual DDSs offer professional development and continuing education opportunities to their employees. For example, some have career ladders based on levels of expertise and performance.

11. How does Social Security limit your ability to pay for expert opinions? Would access to more experts help make better decisions?

Social Security works with the DDSs to determine our budgetary needs, which routinely include the cost of medical and psychological consultants for case assessment and consultative examinations by various specialties, and in some DDSs, vocational specialist positions (see #3 above). SSA provides funding authorization to the DDSs, as available within the overall SSA/DDS budget limitations.

SSA and DDS must prioritize their expenditures, especially in tight budget times. Fee schedules for specialist services are generally guided by Medicare rules and/or State policies. The focus is on policy compliance. If fully funded and if the experts were fully trained in Disability Program policy as well as their area of expertise, using them might help make better decisions.

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Thank you for allowing me the opportunity to address these questions. As always, NCDDD remains available to provide input to the Subcommittee on the complexities of disability decision making and possible approaches to the critical situation facing the Social Security Disability Program. NCDDD members stand ready to participate in the solutions necessary to secure this vital program for present and future generations.

Sincerely,

Trudy Lyon-Hart
President, NCDDD