July 3, 2018

Nancy Berryhill
Acting Commissioner
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235-6401

Submitted via www.regulations.gov

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

Dear Acting Commissioner Berryhill:

These comments are submitted on behalf of the Social Security Task Force of the Consortium for Citizens with Disabilities (CCD). CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society. The CCD Social Security Task Force focuses on disability policy issues in the Social Security Act Title II disability programs and the Title XVI Supplemental Security Income (SSI) program. Thank you for the opportunity to provide these comments on the proposed regulations.

CCD's Social Security Task Force supports strengthening the accuracy and timeliness of disability determinations. SSA's ability to make the correct decision as early in the process as possible benefits both claimants and the agency. Unfortunately, the undersigned CCD Social Security Task Force Co-Chairs are concerned that portions of these proposed regulations would on net only make it harder for eligible claimants with musculoskeletal disabilities to provide the evidence required to be approved for Social Security disability benefits.

As outlined below, we are concerned that many of the changes proposed here, rather than improving the listings to assist in identifying individuals who clearly meet Social Security's definition of disability, will instead result in people who are currently approved at step 3 of the sequential process waiting longer for a decision because further, unnecessary analysis will be completed at steps 4 and 5 of the sequential evaluation. Even more concerning is the possibility that these proposed changes will result in denials at the initial and reconsideration levels for reasons including the limited ability of state agency examiners to obtain vocational or medical expert opinions; in this scenario, claimants would need to file an appeal and wait the unacceptably long time it takes (currently around 600 days) to receive a decision from an Administrative Law Judge (ALJ).

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Further, individuals with disabilities applying for benefits might not be able to afford some of the evaluations or tests incorporated into the criteria in these proposed changes. The inability to afford medical treatment should never be a barrier to receiving Social Security disability benefits for an individual who, if the proper evaluations or tests were administered, would be found to meet all of the eligibility requirements.

Given those overarching concerns, following are comments on the specific changes proposed in the NPRM.

1.00 and 101.00 Musculoskeletal Disorders

Physical Examination Reports (Proposed 1.00C2 and 101.00C2)

Individuals applying for Social Security disability benefits are not in a position to know whether their doctor is administering a test properly or whether they are administering the most appropriate test for that matter. Disability claimants rely on the doctor or other acceptable medical sources to determine which tests to administer and to perform them properly. We therefore strongly support the proposal to assume that medical sources performed tests properly unless there is evidence to the contrary. As noted in the example, this is important in situations like the straight-leg raising test, where providers may not explicitly note that they tested the claimant in both seated and supine positions.

The same is true for the language a treating source uses to describe the results of a test and the resulting functional limitations that a claimant has. We encourage SSA to be inclusive of terminology and types of acceptable tests to ensure that a claimant is not penalized if her doctor uses a medically accepted scale or test but did not use the exact rating scale or language referred to in the final rule. For example, in cases where a reduction in muscle strength is a factor, the final rule should include not just the 0 to 5 grading referred to in the NPRM but also the none/trace/poor/fair/good/normal scale used by Daniels and Worthingham, the percentage scale used by Kendall and McCreary, and descriptions using the same or similar language as Table 1 of the proposed listing (e.g. "active ROM with gravity eliminated" or "active ROM w/o gravity" or other similar language should both be considered as equivalent to grade 2).

Effects of Treatment (Proposed 1.00C5 and 101.00C5)

We are concerned that the proposed changes in this section encourage people with disabilities to seek treatment with opioids who otherwise might not. Given the opioid crisis across the United States, many claimants make significant efforts to avoid opioid prescriptions or minimize the use of such drugs when prescribed; many medical providers are also attempting to use alternative treatments in lieu of opioids where possible. SSA regulations should never have the effect of encouraging certain treatments as a means of proving disability. The final rule should explain here, and in 1.00D and 101.00D, that a lack of opioid prescription or attempts to reduce or avoid opioid use should never be considered indicative of the severity of a musculoskeletal impairment. Nor should it affect an adjudicator's decision about whether such impairments can reasonably be expected to produce a claimant's symptoms (including pain), or about the intensity and severity of such symptoms.

Assistive Devices (Proposed 1.00C6 and 101.00C6)

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

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

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

We are very concerned about the removal of inability to ambulate effectively as a criterion in this listing. Many people with musculoskeletal impairments have functional limitations that prohibit substantial gainful activity (SGA), but do not use assistive devices. We urge SSA to retain the current definition of inability to ambulate effectively: "an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities," rather than requiring the need for a two-handed assistive device to meet this listing. Many individuals will resist using any assistive device even when needed, or might not be able to afford a device, and might still have mobility limitations that make work at or above SGA impossible, including, "the inability to walk a block at a reasonable pace on rough or uneven surfaces, the inability to use standard public transportation, the inability to carry out routine ambulatory activities, such as shopping and banking, and the inability to climb a few steps at a reasonable pace with the use of a single hand rail."

We were unable to find any rationale provided by SSA for this significant change and strongly urge SSA not to include it in the final rule. This change will likely be highly inefficient as people who cannot complete the activities listed above (e.g. climb a few steps without use of a handrail, walk a block at a reasonable pace on a surface with some texture) are extremely likely to be found disabled at steps 4 and 5 of the sequential evaluation process. The National Association of Disability Examiners' (NADE's) 2002 comments on proposed changes to musculoskeletal listings made this point in considerable detail:

> **We strongly dispute any suggestion by SSA that adjudicating claims at steps four and five in the sequential evaluation process can be done as quickly and as efficiently as claims decided earlier in the process.** It is far easier and less time consuming to process claims earlier in sequential evaluation when only medical factors are considered. Claims that require subjective consideration of functional abilities and other vocational factors will require more time to develop than claims that are decided on the basis of objective medical factors alone. SSA is ignoring

> reality to believe otherwise….**If, as expected, the revised listings result in more decisions at steps four and five of sequential evaluation, then this will clearly result in more development costs and increased processing time**.[1]

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

Obesity (Current Listing 1.00Q)

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

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

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

Longitudinal Evidence (Proposed 1.00C7 and 101.00C7)

People with musculoskeletal impairments experience their disabilities and symptoms differently. Some people have symptoms that wax and wane, while others have constant and progressive symptoms. Some are unable to afford or obtain consistent and ongoing treatment due to lack of availability of medical practitioners (especially specialists), lack of affordable or accessible transportation, or financial inability to pay for needed care. The final rule should better reflect this reality and not include a requirement that all criteria for a listing must be present simultaneously or "appear in the medical record within a period not to exceed 4 months of one another." A claimant should not be excluded from being found eligible for benefits on the basis of this listing because she sees multiple providers to obtain diagnosis and treatment, has financial or other barriers to seeking consistent care, experiences relapsing and remitting symptoms, or any other reason that makes it impossible to get documentation and recording of meeting the criteria outlined in this section. When

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

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

[3] See Page 23, https://www.ssa.gov/OACT/presentations/scgoss_20170726.pdf

[4] See https://www.disabilitypolicyresearch.org/download-media?MediaItemId=%7BCA627EB4-5180-4C77-AD68-1AC81D3B0F63%7D

the symptoms, fractures, need for assistive device, or other occurrences that demonstrate that the claimant meets the criteria occurred matters; when they were recorded should not.

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

As noted above, an individual applying for disability benefits is not in a position to know whether her doctor is using the correct terminology that will enable her to be found eligible because her condition meets or equals a listing. Neither are most treating sources aware of the exact terminology used in the Social Security listings. We encourage SSA to include all terms that signify an equivalent level of impairment as "compromise" and "impingement" of a nerve root as meeting the listing in the final rule. This could include terms such as "displacement" of the nerve root (such as from a tumor or traumatic injury), "foraminal narrowing," "foraminal stenosis," "neural foraminal stenosis" and "foraminal encroachment" can all indicate compromise of a nerve root; undoubtedly, medical sources use other terms as well.

Where current listings 1.02 and 101.04 require "pain [or] limitation of motion of the spine, [or] motor loss (atrophy with associated muscle weakness or muscle weakness)," the comparable portions of proposed listings 1.15 and 101.15 require muscle weakness AND "signs of nerve root irritation, tension, or compression, consistent with compromise of the affected nerve root" AND at least one of pain, paresthesias, or muscle fatigue. No explanation is given for the increased requirements; nor for the removal of limitation of the motion of the spine. Spinal motion is critical to numerous activities and should not be removed. The final rule should combine 1.15A and 1.15B (and the corresponding sections in the child listings) and allow them to be satisfied when there is at least one of the following neuroanatomically-distributed (radicular) symptoms, accompanied by sensory or reflex loss as described in 1.15B(2) and (3) and the corresponding portions of the child listings: pain; limitation of motion of the spine; muscle weakness or fatigue; signs of nerve root irritation, tension, or compression; and parasthesias.

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

We highly encourage SSA to remove proposed 1.15C and 101.15C from the final listing. As discussed above, many disability claimants are unable to afford consistent medical care, let alone expensive imaging tests. The proposed listings require imaging to confirm nerve root compromise. This is infeasible for many claimants who cannot afford imaging or whose providers do not feel that imaging is necessary in order to treat their conditions. A disability claimant also will not know that such tests should be ordered to request them, even if she could afford to pay for the tests. The current rules explicitly state that SSA will not purchase CAT scans, MRIs, or myelograms; the proposed rules cite to regulations that discuss the purchase of x-rays but not other types of imaging and specifically state that myelograms will not be purchased. Therefore, while claimant-submitted imaging could help demonstrate that the listing is met, it should not be a requirement.

The final rule should also remove 1.15D and 101.15D. Nerve root compromise that meets the criteria of 1.15A and B (edited as discussed above) and the corresponding sections of the child listings can be disabling even if it does not require the use of an assistive device. An individual whose nerve root compromise causes him or her to experience sensory or reflex loss as well as pain; limitation of motion of the spine; muscle weakness or fatigue; signs of nerve root irritation, tension,

or compression; or parasthesias has significant limitations even if he or she can ambulate without an assistive device and can perform fine and gross motor skills with both upper extremities.

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

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

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

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

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

to consult a vocational resource") and are more subject to adjudicators' subjective perceptions. Eliminating 1.04B is neither fair nor efficient and the final rule should include it.

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

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

The final rule should end these listings after the phrase "at least 12 months." We do not understand how the need for a two-handed assistive device, a one-handed assistive device with impairment to the other upper extremity, or limitations to both upper extremities meaning that "neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements" are necessary functional limitations appropriate to a finding of disability. Claimants who endure three or more fractures at different times in a 12-month period and have resulting musculoskeletal impairments lasting at least 12 months are extremely likely to be found disabled at later stages of the sequential evaluation process; that is why the current listings allow such claimants to be found disabled at step 3 of the process. Such adult claimants will miss work without notice (because fractures are generally sudden and unplanned), require follow-up treatment, be in pain and/or take pain medication that causes distraction and time off task, and experience a variety of exertional and nonexertional limitations that substantially reduce what work is possible. Child claimants will likely have distracting levels of pain, decreased physical function as a result of the fractures and their treatments, and have other effects that result in marked or extreme limitations in the required number of domains. Forcing adjudicators to proceed past the listings when considering such claims will result in decisions taking longer, require the agency to hire medical and vocational experts in more claims, and send more claims to the ALJ level rather than having them adjudicated at the state agency.

Proposed Listings 1.20 and 101.20 (amputation due to any cause)

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

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

Proposed Listings 1.23 and 101.23 (nonhealing or complex fracture of an upper extremity)

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

There is no indication that an adult claimant with a complex or unhealing fracture, under continuing surgical management, causing a limitation in musculoskeletal functioning that has lasted or is expected to last at least 12 months, would be able to perform SGA. Similarly, such child claimants would likely have marked or extreme limitations in the required number of domains. This is because such individuals would, by definition, need surgery, likely requiring time away from school or work, with additional time away for preparation and recovery from surgery. As indicated in the NPRM regarding proposed listing 1.21, SSA has a "long-standing recognition that extensive, prolonged treatment in order to re-establish or improve function of the affected body part(s) may contribute to an inability to perform work-related activity." The treatment required for the type of fracture contemplated in proposed listings 1.23 and 101.23 are themselves likely to be disabling.

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

Thank you for the opportunity to submit these comments. We urge SSA to reconsider some of these changes that will lead to inefficiencies in the disability claims process, requiring DDS examiners to complete additional analysis to come to the same result or requiring the claimant to appeal a denial and wait for a decision from an ALJ.

Sincerely,
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