CONSORTIUM FOR CITIZENS WITH DISABILITIES

November 8, 2016

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

Submitted on www.regulations.gov

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

Dear Acting Commissioner Colvin:

The undersigned organizational members of the Consortium for Citizens with Disabilities (CCD) are pleased to submit the following comments regarding Notice of Proposed Rulemaking on Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. 62559 published on September 9, 2016 (Docket No. SSA-2012-0035). 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 (SSTF) focuses on disability policy issues in the Title II disability programs and the Title XVI Supplemental Security Income (SSI) program.

Thank you for the opportunity to comment on the proposed regulations contained in this Notice of Proposed Rulemaking (NPRM). While the undersigned organizations generally support SSA's efforts to keep its rules current with changes in the national healthcare workforce, simplify and reorganize its rules for ease of use, and allow SSA to continue to make accurate and consistent decisions, these rules as proposed will not accomplish those goals. The undersigned members of CCD object to many aspects of the proposed rules regarding the evaluation of medical evidence and urge SSA not to move forward with finalizing these regulations.

The general objections of the undersigned CCD members are as follows:

- These rules will not lead to more accurate decisions or decrease processing time. If anything, they will lead to more appeals, more remands, and more delays. The process of training adjudicators on this complex new regulation and adapting SSA systems to comply with it will be difficult, time-consuming, and expensive.

- SSA should continue requiring decisions to provide the rationale for how the decision was made. The provisions in this proposed rule that remove the responsibility of adjudicators to explain how they weigh certain evidence and prior administrative decisions, for example, is likely to increase appeals and court remands rather than decrease them. Courts will not be able to determine whether "substantial evidence" supports SSA's decision if adjudicators need not adequately explain how they arrived at their decisions.
- Some of the provisions contained in this NPRM appear to be at odds with the Social Security Act.
- Some of the changes proposed in this NPRM are not evidence based and do not rely on current data. For example, to our knowledge, SSA has not attempted to adjudicate a sample of claims under the current and proposed rule to compare the speed and accuracy of determinations under each set of policies.

The undersigned members of CCD urge SSA to withdraw most of this NPRM and to only move forward the expansion of acceptable medical sources, with further expansions of acceptable sources. Specifically:

- **Acceptable Medical Sources (20 CFR §404.1502(a) and §416.902(a)):** We strongly support SSA's proposal to add audiologists and licensed advance practice registered nurses (APRNs) to the list of "acceptable medical sources." However, we urge greater expansion, including physician assistants (PAs) and licensed clinical social workers (LCSWs), based on the reality of who in the current healthcare workforce provides treatment.
- **Decisions by other governmental agencies and nongovernmental entities (20 CFR § 404.1504 and § 416.920b):** The undersigned organizations oppose SSA's proposed revisions to how decisions by other governmental agencies and nongovernmental entities are considered. SSA should require adjudicators to articulate whether and to what extent medical opinions and prior administrative medical findings are considered.
- **How SSA Considers Evidence (20 CFR § 404.1520c and §416.920c):** Many changes in the NPRM are premised on the idea that individuals no longer have relationships with treating sources. We disagree with that premise. As SSA recognizes when proposing expanding "acceptable medical sources," treating sources are not (and truly never were) all physicians. The undersigned organizations support the current rule, which requires adjudicators to give treating source opinions from acceptable medical sources controlling weight in most circumstances; when such opinions are not given controlling weight, the adjudicator must explain why not. Our organizations also support giving *additional* weight to opinions from acceptable medical sources than from those who perform a single examination or a review of a paper file, even in situations where *controlling* weight may not be appropriate. The inability of some SSA adjudicators to adequately explain how they weighed conflicting evidence does not justify treating all evidence equally, but rather argues for better training of adjudicators.

The undersigned organizations urge SSA to withdraw the proposal to eliminate the treating source rule and the proposal to no longer give controlling (or any additional weight) to evidence received from a treating acceptable medical source. The relationship a claimant has with a treating source means treating source opinions deserve more weight than the opinions of an

individual who performs a single examination or reviews a claimant's paper file. Should SSA move forward with eliminating controlling weight for treating sources, the undersigned organizations urge the agency to retain the rest of the current framework for giving treating sources additional weight and adopt the suggestions contained in these comments. Our organizations fully support expanding the list of acceptable medical sources, but urge SSA to go further than proposed and include additional treating sources as acceptable. Our specific comments to the proposed rules appear below.

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

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

Likewise, for LCSWs, all states have a minimum educational requirement of a Master of Social Work degree and require passage of one of four of the exams offered by the Association of Social Work Boards (ASWB), typically the clinical exam.[2] Similar to APRNs, supervised post-degree experience is an additional requirement for LCSWs in most states, ranging from 3,000 hours to 24 months.[3] In addition, a substantial number of people with mental health conditions and psychiatric disabilities have LSCWs as their primary mental health care providers. The National Association of Social Workers estimates that 60% of mental health professionals are clinical social workers, compared to 10% who are psychiatrists, 23% who are psychologists, and 5% who are nurses.[4] Therefore, the undersigned members of the CCD support the addition of audiologists and APRNs to the list of acceptable medical sources, and would support adding both PAs and LCSWs to this list.

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

The undersigned members of CCD recommend that SSA also include chiropractors and physical therapists as acceptable medical sources within the specific scope of practice requirement. Doing so not only recognizes the way many people receive medical care today, but would also create a uniform rule and reduce the number of cases filed in federal courts, which are ultimately remanded due to the ALJ's failure to give proper consideration to medical evidence provided by these sources. Including them specifically in the list of acceptable medical sources would clarify the rule. These medical professionals are also subject to strict education and licensing

[1] https://www.aapa.org/become-a-pa/.
[2] http://aswbsocialworkregulations.org/jurisdictionLevelsReport.jsp.
[3] *Id.*
[4] https://www.socialworkers.org/pressroom/features/issue/mental.asp.

requirements. For example, in *Santiago v. Bowen*, 715 F.Supp.614 (S.D.N.Y. 1989) the court noted the rigorous four-year training of chiropractors, which is the same length as medical school, and the licensing requirements in the state of New York. In *Barrett v. Barnhart*, 355 F.3d 1065 (7th Cir. 2004), the court recognized that patients are more likely to seek relief from chronic problems from a physical therapist than an orthopedist. Properly trained physical therapists can provide personalized treatment and often have ongoing treatment relationship with their patients.

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

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

Our organizations oppose the proposal to rescind Social Security Ruling (SSR) 06-3p and change how disability decisions from other governmental agencies and nongovernmental entities ("other agencies") are considered. SSR 06-3p was correct when it said "<u>These decisions, and</u> the evidence used to make these decisions, may provide insight into the individual's mental and physical impairment(s)" (emphasis added); the decisions themselves, and not just the evidence used to make the decisions, have value. Our organizations recognize that other agencies have different standards for determining disability and agree that SSA need not be bound by other agencies' determinations, but it is our position that SSA adjudicators should, as SSR 06-3p currently requires, "explain the consideration given to these decisions in the notice of decision for hearing cases and in the case record for initial and reconsideration cases." This is in keeping with the Social Security Act, which requires the agency to make determinations "on the basis of evidence adduced at the hearing." Allowing adjudicators to ignore this specific class of evidence does not comport with the Social Security Act.

It is not accurate to say, as does the preamble to the proposed rule, that "other governmental agencies' or nongovernmental entities' decisions give us little indication whether a claimant is more or less likely to be found disabled or blind under the Act." Although the probative value of other agencies' or entities' decisions will obviously vary, SSA's own research shows that veterans with 100% disability ratings or an IU ratings are substantially more likely to be found disabled than the general population of SSDI applicants.[5] Further, some United States Courts of Appeal have held that SSA should give great weight to VA decisions absent a reasoned, fact-specific explanation for discounting those decisions. The proposed rule would abrogate these court decisions. Ignoring probative evidence could result in inappropriate denials of the SSA claims of some veterans with disabilities.

In addition, VA regulation 38 CFR Section 3.159(c)(2) requires VA to "make as many requests as are necessary to obtain relevant records from a Federal department or agency." Relevant records include those in the custody of SSA. The Court of Appeals for Veterans Claims further noted the following in Hayes v. Brown, 9 Vet.App. 67, 73-74 (1996):

[5] *See* https://www.ssa.gov/policy/docs/ssb/v74n3/v74n3p1.html Chart 16.

> This Court has stated that '[w]hen VA is put on notice prior to the issuance of a final decision of the possible existence of certain records and their relevance, the BVA [Board of Veterans Appeals] must seek to obtain those records.' Murincsak v. Derwinski, 2 Vet.App. 363, 373 (1992). As part of the Secretary's obligation to review a thorough and complete record, VA is required to obtain evidence from the Social Security Administration, including any decisions by the administrative law judge, and to give that evidence appropriate consideration and weight. Id. at 372; see Collier v. Derwinski, 1 Vet.App. 413, 417 (1991) (Social Security Administrations records are pertinent to the appellant's VA claim).

Case law governing both SSA and VA claims generally supports weight being given to the decisions of those agencies by the other. Indeed, although there are some variations between the circuits in how much weight a VA decision is due, the majority rule is that it is entitled to at least some weight—usually significant weight—and cannot be simply brushed off with a statement that it is "not binding" on the Agency, with no further discussion.

While veterans with service-connected disabilities rated at 100 percent are likely to fall within the SSA listings of impairments and conditions that qualify for SSDI, the proposed change to SSA' medical evidence processes could adversely impact veterans with lower VA disability ratings. For example, veterans with disabilities rated between 60 and 90 percent usually also qualify for SSDI. Although SSA says that it will continue to consider evidence from the VA's determination of these ratings, the NPRM indicates SSA will no longer explain how it uses that information in its own decisions. This could place a veteran with a significant disability at a disadvantage if he or she is denied SSDI on application and finds it necessary to appeal that decision.

Our organizations strongly support continuing SSA's current policy of expediting claims for those classified as "military casualty/wounded warriors" and for veterans with 100% permanent and total disability compensation ratings from the VA. Given that veterans with 100% disability compensation ratings have a high award rate for Social Security disability benefits when they do apply,[6] the undersigned organizations urge SSA to continue considering VA disability ratings and other agency or entity decisions when making disability determinations and not just in determining the order in which claims are processed.

The undersigned organization agree that some claimants' files may not have complete information about the reasons underlying another agency's determination. But some files do contain this information, and our organizations disagree with the proposed rule, which would release adjudicators from the need to consider it. In addition, another agency's disability determination may include in the same document the decision about whether to issue benefits and other information that may be important for assessing medical and non-medical criteria for Social Security disability benefits. Such a determination could include information about a claimant's income, work history, marital status, or immigration status. It could include an adjudicator's observations of the claimant or information about the medical treatment a claimant receives. Modifying 20 CFR §§404.1504 and 416.904 to state that SSA "will not provide any analysis in our determinations and decisions about how we consider decisions made by other

[6] *See id.* at Chart 4.

governmental agencies or nongovernmental entities" means that claimants and their representatives will have no way of knowing whether the SSA adjudicator reviewed the evidence at all, or whether the adjudicator gleaned these or other important pieces of information from the determination. The proposed rule does not forbid consideration of other agencies' determinations, so it is possible that an SSA adjudicator would consider another agency's determination but not state that they did so. An adjudicator could, conversely, fail to consider another agency's determination and never explain why. It will be impossible to know, therefore, whether the adjudicator's decision was based on substantial evidence. This change would take SSA decisions further away from the standards articulated in numerous federal court cases, including the Ninth and Fourth Circuit cases cited in footnote 42 of the NPRM. These cases require the agency to provide great or substantial weight to VA determinations, absent reasoned and fact-specific explanations. Changing the rules so that adjudicators are not required to give any weight to VA determinations and never have to explain their reasoning on this topic would therefore lead to more appeals and probably more remands.

A better approach than the one proposed in the NPRM would be to provide additional training and more quality reviews of adjudicators' decisions. Helping DDS examiners and Administrative Law Judges (ALJs) to articulate how they weighed these decisions is consistent with the jurisprudence in cases where other agencies' decisions were at issue. The undersigned organizations urge SSA to preserve SSR 06-3p, withdraw this regulatory proposal, increase the training provided to adjudicators regarding articulating how other agencies' or entities' decisions were weighed, and conduct more quality reviews of written decisions to identify training needs.

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

The undersigned organizational members of CCD strongly oppose the changes proposed in this section. Our organizations support the current rule, which requires adjudicators to give treating source opinions from acceptable medical sources controlling weight in most circumstances; when such opinions are not given controlling weight, the adjudicator must explain why not. The undersigned CCD members urge SSA not to change these rules. The reasons provided in the preamble to the proposed rule are not compelling. It is the position of our organizations that the proposed changes will reduce accuracy of decisions and will undermine the legitimacy of decisions by making them significantly less transparent.

This proposed rule would give adjudicators excessive discretion with little direction as to how it should be applied. SSA's current rules on the topic are clearer, and the treating physician rule already has safeguards in place to ensure that the only medical opinions given controlling weight are those that are consistent and well-supported by the record.

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

As the Supreme Court noted in *Black & Decker v. Nord*, "The treating physician rule at issue here was originally developed by Courts of Appeals…"[7] based on the requirements in the Social Security Act itself. SSA would exceed its authority if it eliminated the need to give more weight

[7] 538 U.S. 822, 828 (2003).

to treating sources than to non-treating sources through the regulatory process. The Act's specific requirement that "the Commissioner of Social Security shall make every reasonable effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis"[8] indicates that Congress recognized special knowledge that a treating source can provide regarding a claimant's impairments and the inherent value in this medical evidence. This section indicates that special consideration should be given to the opinion of a treating physician or other treating health care provider. Prior to the 1991 regulatory scheme enacted to codify the treating physician rule, courts certainly interpreted the statute that way. It is likely that courts would invalidate a regulatory change that places treating sources on equal footing with non-treating sources, given their consistent interpretations of the statute to impose a treating professional deference rule before the regulations codified that rule in 1991.

SSA's reliance on *Black & Decker* in the NPRM is misplaced and does not support an elimination of the entire evidence evaluation framework currently in place. Neither does the Administrative Conference of the United States (ACUS) report SSA commissioned in 2013.[9] ACUS, when reviewing SSA's treating physician rule, relied on a phrase in *Black & Decker*: "And if a consultant engaged by a plan may have an 'incentive' to make a finding of 'not disabled,' so a treating physician, in a close case, may favor a finding of 'disabled.'" In the preamble to the NPRM, SSA interpreted this statement to mean that treating sources are more likely to find that the claimant is disabled. But this is not what the Supreme Court said. In *Black & Decker*, the Court made a comparison: if doctors paid by benefit plans might lean towards finding a claimant not to be disabled, it would follow that treating doctors might be more inclined to find a patient is disabled. But the Court does not say anything about a "built-in evidentiary bias." Instead, the Court simply held that SSA's treating physician rule is not applicable in ERISA cases. The Court reasoned that SSA has regulations which govern the weight to be applied to a treating physician's opinion in a Social Security disability claim. But because no similar Department of Labor regulations exist, and because the ERISA statute itself does not contain any reference to evidence from a treating source (in contrast to the Social Security Act), the Supreme Court held that the courts cannot require application of a treating physician rule to employee benefit claims made under ERISA. *Black & Decker* should not be read to conclude that treating physicians cannot issue unbiased medical opinions regarding their patients, nor that the current regulatory provisions creating the additional weight given to treating sources is inappropriate or needs to be changed.

[8] Section 223.

[9] Administrative Conference of the United States, SSA DISABILITY BENEFITS PROGRAMS: ASSESSING THE EFFICACY OF THE TREATING PHYSICIAN RULE, Final Report: April 3, 2013, https://www.acus.gov/sites/default/files/documents/Treating_Physician_Rule_Final_Report_4-3-2013_0.pdf

B. Increases in the Complexity of Cases and Size of Files Do Not Justify Changing the Regulatory Framework for Evaluation of Evidence

One reason put forth by SSA for eliminating the current treating source rule is that some claims files are too large for adjudicators to properly consider all of the evidence.[10] SSA also asserts that people now see more specialists and often submit evidence from a variety of sources, making it harder for adjudicators to apply the treating source rule. These facts argue for SSA to instruct its adjudicators on how to weigh opinions from multiple treating sources instead of eliminating the rule altogether. If the current rule no longer reflects current treatment scenarios, it should be revised to account for the current situation of managed care and multiple treating sources (including but not limited to physicians), while still granting controlling weight to the opinion of a treating source or primary care provider. People may have multiple providers because they have multiple impairments. It is possible to create a rule that allows adjudicators to give opinions more weight when they are about the impairment for which a provider provided treatment.

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

Concerns about "voluminous case files" do not justify reducing adjudicators' responsibilities. The proposed rule could amount to a denial of a claimant's right to have his or her case decided on the totality of the evidence and a violation of the adjudicator's long-standing duty to make a decision based on all of the evidence in the record.[11] Case files are longer for many reasons, including SSA's all evidence rule,[12] long processing times, and the repetitive nature of electronic medical records. People with long claims files are no less likely to be disabled, and no less deserving of due process, than people with short claims files. SSA adjudicators are required to make a decision based on all of the evidence in the record. If there is too much evidence, then SSA might consider revising the recently enacted rules requiring submission of all evidence and reduce hearing-level processing times. These have resulted in voluminous files. Allowing adjudicators to disregard relevant evidence, or no longer requiring them to articulate how they considered that evidence, are not acceptable solutions.

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

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

[12] 20 CFR §404.1512(a) and 416.912(a).

Instead of removing the articulation requirements, SSA should give adjudicators and their support staff the training and support they need to do their important work properly. Removing adjudicators' responsibility to "show their work" will not reduce appeals and remands. A federal judiciary that currently remands many cases to the Commissioner due to articulation errors is unlikely to be more deferential to an agency that simply stops articulating at all. In fact, the courts might even find these regulations to be impermissible.

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

As mentioned above, our organizations dispute the assertion that, because of the changing nature of healthcare, people no longer have treating sources whose opinions deserve more weight based on their ongoing treatment relationships with claimants. Although it is true, in certain cases, that some people no longer have a primary care physician, most people who have chronic conditions and disabilities have ongoing relationships with some type of healthcare provider, particularly in light of the prevalence of managed care arrangements. Those providers might be APRNs, PAs, LSCWs, physical therapists, or audiologists (just to name a few) rather than doctors, but the treating relationship is still important and still deserves the value placed on it by the existing treating source rules.

The 2013 ACUS report cites several studies indicating some people change their primary care providers due to insurance changes or personal preference, but those studies actually showed that many people keep their providers for long periods of time—certainly long enough to establish a relationship exceeding what one might encounter in a consultative examination or file review.[13] It is also possible that as the Affordable Care Act allows more people to obtain medical insurance and carry it with them between jobs, and as more Baby Boomers qualify for Medicare (with several years in which they might apply for or receive SSDI, due to the increase in the full retirement age), some people are experiencing more consistent medical treatment than they did in the past. Although the way some patients receive medical care has changed since the current rules were issued in 1991, if a patient does have a long-standing relationship with a long-time treating source, the opinion of such a medical source should continue to be given its current weight. The ACUS report does not deny the importance of a long-standing treating source/patient relationship when one does exist.

The relationship between a person and their treating provider is unique and the opinions of treating providers deserve more weight than the opinion of someone who either examines an individual once or only reviews the claims file. The evidence from a treating source is generally more persuasive because treating providers *treat*. Providing effective treatment to a person typically requires a much greater depth of knowledge and information than that relied on by

[13] ACUS, *supra* note 10, at fn.221. For example, the ACUS paper describes a 2003 study by Paul Nutting et al. as "summarizing studies showing that only about 50% of surveyed patients reported continuity of regular physician," but Nutting's study itself states that "In the practice settings examined in this report, more than 90% of patients saw their regular physician. In these family practices it appears that patients were able to achieve continuity for many of those visits in which it is hypothesized to be important." http://www.hpm.org/Downloads/Bellagio/Articles/Continuity/Nutting_et_al_2003_3ItemsMeasure_Continuity.pdf The ACUS paper also cites a 2000 study where 24% of the surveyed population had been forced to change family doctors in the previous three years due to insurance change; this indicates that the vast majority were able to maintain their primary care providers for at least three years.

professionals merely performing an evaluative function. A provider would not prescribe medication, recommend tests, give advice, refer to a specialist, perform surgery, or provide other treatments unless they found the patient's reports and their own observations and conclusions persuasive enough to require these actions.

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

When a treating or primary care source relationship does exist, the current rules continue to be appropriate. Furthermore, it should be possible for SSA to give controlling weight to one provider for one impairment and another provider for another impairment, or to reconcile opinions that differ or conflict. Assessing multiple pieces of evidence, reconciling inconsistencies, and arriving at a policy-compliant decision is precisely the job of an adjudicator.

D. Treating Sources Should Still Receive Additional Weight Even if Not Controlling Weight

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

SSA fails to explain why the factors adjudicators must currently use to determine what weight to give opinion evidence need to be altered, or why the order in which the factors are applied should be changed. It is the position of the undersigned organization that the first factors to be examined should continue to be whether the source has examined the claimant and the nature and length of the treatment relationship, followed by whether the opinions are supported and consistent.[14] SSA should continue to include whether or not the treating source is a specialist as a factor in determining whether to give controlling or additional weight to a treating source.

However, our organizations strongly oppose two factors the NPRM would use to evaluate the persuasiveness of evidence: familiarity with SSA rules and having completed a review of the entire file. These factors tip the scale toward Consultative Examiner (CE) or Medical Consultant (MC) opinions and SSA does not provide a compelling rationale for including these factors. These two factors actually reflect the role of the adjudicator – being familiar with SSA rules and reviewing the entire file – and not the role of a medical source, especially because making

[14] See 20 CFR §404.1527(a)

determinations that reflect knowledge of SSA's policies are not required unless a source might be making a determination that is generally reserved for the Commissioner.

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

Some opinions are written down long before a case file even exists but that does not make them less persuasive. At the same time, when a MC reviews a file at the initial level, given the extremely long delays waiting for hearings, it is likely that the individual's conditions have changed and significantly more evidence is in the file. The MC reviewed the entire file at the time of the initial decision, but not the entire file by the time an ALJ makes a decision. As written, an ALJ could find the MC opinion more persuasive, even though the MC reviewed a record lacking material evidence available at the time of the appeal.

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

IV. Other Proposed Changes

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

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

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

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

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

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

Our organizations also urge SSA to clarify that merely using terms that appear in listings, domains, the medical-vocational grids, or elsewhere in SSA's law and regulations does not indicate that a statement is on issues reserved to the Commissioner. Words like "moderate," "marked," "sedentary," and other terms are frequently used by medical providers and others. An adjudicator need not be bound to others' conclusions on issues reserved to the Commissioner. But adjudicators should be cautioned not to ignore statements that are on issues not reserved to the Commissioner just because they use words that appear in SSA's own laws and policies. As an example, "Mrs. Smith is restricted to sedentary work" is a statement on issues reserved to the Commissioner, but "Mr. Jones has led a more sedentary lifestyle since his accident and can no longer climb stairs or stand without a cane" is not. Similarly, diagnostic terms used widely by medical professionals, such as "intellectual disability" should not be ignored because they include the word "disability."

Conclusion

The undersigned members of CCD urge SSA to withdraw most of this NPRM and to only move forward the expansion of acceptable medical sources. We urge the agency to further expand the list with the inclusion of PAs and LCSWs, as well as chiropractors and physical therapists. Our organizations strongly oppose the proposed changes to the way SSA will consider decisions by other governmental agencies and entities, and the changes SSA proposes to make to how evidence from treating and non-treating sources will be evaluated. Our organizations emphatically support maintaining the current rule recognizing the "intrinsic value" of the treating source/-patient relationship and urges SSA to continue to afford such opinions controlling weight when the requirements for consistency and supportability are met. Should SSA choose to move forward with eliminating the controlling weight aspect of the way it currently evaluates evidence from treating sources, SSA should maintain the rest of the current regulatory framework for giving treating sources additional weight over non-treating sources based on the nature and the length of the treating relationship.

Thank you for considering these comments.

Sincerely,

ACCSES
American Association of People with Disabilities
American Association on Health and Disability
American Association on Intellectual and Developmental Disabilities (AAIDD)
American Network of Community Options and Resources (ANCOR)
Association of University Centers on Disabilities (AUCD)
Autistic Self Advocacy Network
Bazelon Center for Mental Health Law
Center for Public Representation
Christopher & Dana Reeve Foundation
Community Legal Services of Philadelphia
Disability Rights Education and Defense Fund (DREDF)
Easterseals
Family Voices
Justice in Aging
Lakeshore Foundation
Lutheran Services in America Disability Network
Mental Health America
National Alliance on Mental Illness
National Association of Disability Representatives
National Committee to Preserve Social Security and Medicare
National Council on Independent Living (NCIL)
National Disability Institute
National Disability Rights Network
National Health Law Program
National Multiple Sclerosis Society
National Organization of Social Security Claimants' Representatives
Paralyzed Veterans of America
Special Needs Alliance
TASH
The Arc of the United States
United Cerebral Palsy
United Spinal Association