

2019

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Recommended Citation

Bindbeutel, Burke (2019) "Medically Acceptable and Acceptably Medical: Social Security Revises Evidence Rules for Disability Claims," *Saint Louis University Law Journal*: Vol. 63 : No. 2 , Article 7.
Available at: <https://scholarship.law.slu.edu/lj/vol63/iss2/7>

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MEDICALLY ACCEPTABLE AND ACCEPTABLY MEDICAL: SOCIAL SECURITY REVISES EVIDENCE RULES FOR DISABILITY CLAIMS

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INTRODUCTION

The Social Security Administration (the “SSA”) distinguishes “acceptable medical sources” (“AMS”) from “other medical sources” in that it allows evidence of “medically determinable impairment” (“MDI”)¹ only to be provided by the former.² On January 18, 2017, the SSA revised their rules about the observations and opinions of medical workers in the determination of disability.³ For disability claims filed after March 27, 2017, the group of “acceptable medical sources” was expanded to include physician assistants (“PA”), licensed

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1. To qualify for benefits, claimants to Social Security Disability Income (“SSDI”) must allege a “severe impairment,” defined by the agency as “any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities.” 20 C.F.R. § 404.1520(c) (2017). The severe impairment must also be “medically determinable,” that is, there must be “medical signs or laboratory findings” that “show that a medically determinable impairment(s) is present.” 20 C.F.R. § 404.1529(b) (2017) “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.” *Id.*

2. Acceptable medical sources, whose objectively observed findings and opinions can establish severe impairment, are the *sine qua non* of disability analysis. It is only once their evidence establishes a medically determinable impairment that analysis can proceed to how that impairment affects a claimant’s capacity for work. “Once we establish that a claimant has an MDI based on objective medical evidence from an AMS, we use all evidence from all sources for all other findings.” SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYSTEM, DI 22505.003 *Evidence from an Acceptable Medical Source (AMS) (A)(3)* (2017), <https://secure.ssa.gov/poms.nsf/lnx/0422505003> [<https://perma.cc/P5JX-3E33>] [hereinafter POMS].

3. Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. 5844 (Jan. 18, 2017) (to be codified at 20 C.F.R. 404), <https://www.federalregister.gov/documents/2017/01/18/2017-00455/revisions-to-rules-regarding-the-evaluation-of-medical-evidence> [<https://perma.cc/8M4K-CZFN>].

audiologists, and advanced practice registered nurses (“APRN”), provided that these health workers are acting within the scope of their practice.⁴

The expansion of AMSs reflects who provides medical treatment today. Much of the observation and analysis in clinical settings is carried out not by medical doctors, but by nurses and other specialists.⁵ The expansion of the role of the physician assistant and registered nurse in delivering medical care had, until the revision, not been reflected in the disability evaluation process. Now, the observations and opinions of these workers can be evaluated by disability judges (known as administrative law judges, or ALJs) in the determination of severe impairment. Their observations could form a broader basis on which to rest theories of disability.

The SSA’s shift must be understood in conjunction with other revisions that the SSA made to its evaluation of medical evidence. In the past, the opinions of medical providers with a treating relationship to a claimant were given controlling weight, provided they were “well-supported by medically acceptable clinical and laboratory diagnostic techniques and [were] not inconsistent with the other substantial evidence.”⁶ This treating source rule (“TSR”), which allowed for deference to a treating doctor’s opinion about a claimant’s ability to work, has been eliminated.

After the elimination of the TSR, all medical opinions in a claimant’s file will be evaluated individually based principally on the opinions’ consistency and supportability.⁷ Other characteristics of medical evidence are also included in the analysis of opinions, including examining relationship and treatment relationship, but consistency and supportability are the main criteria for persuasiveness.

Similar to the expansion of acceptable medical sources, the revision of medical opinion evaluation signals a shift away from reliance on medical doctors.⁸ The expansion of AMSs invites non-doctors to offer persuasive

4. *Id.* at 5847; POMS, (AMS), *supra* note 2.

5. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, IMPROVING ACCESS TO ADULT PRIMARY CARE IN MEDICAID: EXPLORING THE POTENTIAL ROLE OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS (Mar. 2011), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8167.pdf> [<https://perma.cc/T5R6-67ZE>].

6. 20 C.F.R. § 404.1527(a)(2) (2017).

7. Revisions to Rules Regarding the Evaluation of Medical Evidence, *supra* note 3, at 5858.

8. The SSA indicates that medical opinions can be provided by any medical source, and further states that the SSA will “consider” all evidence from non-medical sources. *Revisions to Rules Regarding The Evaluation Of Medical Evidence*, <https://www.ssa.gov/disability/professionals/bluebook/revisions-rules.html> [<https://perma.cc/4F6N-T74E>], Q&A 8 (last visited Oct. 10, 2018) (providing clarification on the rules in question and answer format). “We will continue to consider all evidence we receive from all sources.” *Id.* at Q&A 8. But severe impairments can only be surmised from the findings of acceptable medical sources. POMS, (AMS), *supra* note 2. Accordingly, if the findings of workers who are not acceptable medical sources can never illustrate

findings.⁹ And the elimination of the TSR forecloses the possibility that a treating doctor could settle the issue of disability on their own. The primacy of the doctor is replaced with diffuse, specialized roles. The purpose of this article is to identify and analyze the normative assessment beneath the changed rules, and to try to anticipate how the SSA's determinations will change once claims are adjudicated under the revisions.

I. REVISIONS TO MEDICAL EVIDENCE RULES

Claimants to Social Security Disability Benefits (Title 2) must allege a medically determinable impairment, and they must allege that their condition results in a limited capacity to perform work.¹⁰ Claimants necessarily rely on medical professionals to establish a limitation that is "medically determinable."¹¹ The statute in fact declares that there cannot be a finding of disability "unless medical signs or laboratory findings show that a medically determinable impairment(s) is present."¹²

In the recent revisions, the administration describes its goal to "reflect modern healthcare delivery."¹³ To this end, APRNs and PAs are now acceptable medical sources and can serve as interpreters of a claimant's symptoms in the disability determination process.¹⁴

A. *The Doctor-Patient Relationship Re-examined*

For the purpose of establishing impairments, APRNs and PAs now find themselves on equal footing with doctors. And, since the TSR has been eliminated, the SSA will no longer assign controlling weight to a treating doctor's opinion. Workers that have been historically subordinate to doctors will now assume the responsibility of describing the extent of medical impairment.

The shift from a doctor making findings to an expanded group of medical professionals making findings indicates that the SSA's disability analysis has

severe impairment on their own, then their observations can only offer enhanced understanding of already-established impairment.

9. Examples of such non-diagnosing workers include psychiatric nurses, who offer consolation but do not prescribe, and physical therapists, who develop goals and collaborate on decisions with patients. *See* POMS, (AMS), *supra* note 2. If these workers, through their work with claimants, gain insight into the extent of a claimant's impairment, this insight may be considered provided it does not take the form of an opinion, which would only be considered if it came from an AMS.

10. 20 C.F.R. § 404.1520 (2017) (outlining the five-step sequential evaluation process for determining whether a claimant is disabled).

11. 20 C.F.R. § 404.1529(b) (2017).

12. *Id.*

13. *See* Revisions to Rules Regarding the Evaluation of Medical Evidence, *supra* note 3, at 5844.

14. *Id.* at 5844, 46–47.

moved past the primacy of the doctor-patient relationship. Indeed, the fact of having examined a patient is no longer a principal factor in the way the SSA evaluates medical opinions.¹⁵

The SSA notes pragmatically that treating relationships are less important today than they were in the past, and that much treatment is provided by sources who were not, before the revisions, considered acceptable medical sources:¹⁶

Since we first adopted the current treating source rule in 1991, the healthcare delivery system has changed in significant ways that require us to revise our policies in order to reflect this reality. Many individuals receive health care from multiple medical sources, such as from coordinated and managed care organizations, instead of from one treating AMS. These individuals less frequently develop a sustained relationship with one treating physician. Indeed, many of the medical sources from whom an individual may seek evaluation, examination, or treatment do not qualify to be “treating sources” as defined in current 404.1502 and 416.902 because they are not AMSs. These final rules recognize these fundamental changes in healthcare delivery and revise our rules accordingly.

The SSA notes that sixty-five million Americans live in places designated by Health and Human Services as having a shortage of primary care providers.¹⁷ This imbalance has led to longstanding federal policy that has advanced the roles of nurse practitioners (“NP”) and PAs in rural and low-income health care.¹⁸ The Balanced Budget Act of 1997 made Medicaid easier to distribute reimbursements for NP and PA service.¹⁹ Permitting NPs and PAs to receive Medicare and Medicaid reimbursement in particular has allowed these non-doctors to meet the medical needs of underserved communities.

These broad shifts in the medical labor market mean that the medical file of a disability claimant today is more likely to contain evidence from non-doctors. And the SSA has reacted by adopting new criteria for the persuasiveness of this

15. *Id.* at 5856 (“Our rules focus on the content of the opinions in evidence, rather than the source of the evidence.”). *But see* 20 C.F.R. § 404.1519h (2017) (“When, in our judgment, your medical source is qualified, equipped, and willing to perform the additional examination or test(s) for the fee schedule payment, and generally furnishes complete and timely reports, your medical source will be the preferred source for the purchased examination or test(s).”); POMS, *supra* note 2, at DI 22510.001 *Introduction to Consultative Examinations (CE)* (discussing how the revision favors the opinions of treatment providers for consultative evaluations—appointments where a doctor chosen by SSA examines and performs a functional capacity evaluation). While it is not clear that this preference indicates a policy of sending disability claimants to their own doctors for functional capacity evaluations, this preference indicates a latent value in the findings and opinions of the treatment provider—precisely the value that the revisions are moving past.

16. *See* Revisions to Rules Regarding the Evaluation of Medical Evidence, *supra* note 3, at 5853.

17. *See* KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *supra* note 5, at 1.

18. *Id.* at 2.

19. *Id.*

evidence. The recent revisions guide judges' evaluation of the opinions of acceptable medical sources. Whether these "medical data sources" have longstanding relationships with patients, or whether they have specialized knowledge, or whether they have even examined a patient, are no longer the most important criteria for ALJs' processing of a claimant's symptomatology. The new rules mean that provided a worker has an opinion that is both consistent and supportable, they can determine disability.²⁰

In an explanation of its elimination of the TSR, the SSA strikes a tone of egalitarianism among the variously-credentialed health providers that disability claimants see (and even the ones they don't see).²¹ The TSR, the SSA implies, created an "automatic hierarchy" between workers who examined claimants and those who did not.²² Further, the SSA indicates that more and more patients receive treatment from "coordinated and managed care organizations," rather than a single provider.²³ The SSA cites a Kaiser Family Foundation study, which does not note an increased reliance on managed care organizations, but does mention the reduced labor costs of such organizations.²⁴

The SSA's new rules allow for the persuasiveness of non-doctors. But at the same time, the revision flattens the various notes and opinions of health care workers, including those who have never treated or examined a claimant, into an array of "data sources." A polyphonic range of information replaces the evidence from a treating doctor, and the SSA is free to assign persuasiveness to any and all of it.

B. *Suitably Credentialed Data Sources*

Social Security has drawn a bright line as to which types of medical providers can credibly note functional impairment.²⁵ The revised regulation describes education and credentials as key to the persuasive assessment of medical impairment. For example, independently practicing psychologists' opinions will be assessed based on whether they have a masters-level degree or a doctorate.²⁶ Further, the elevation of the opinions of APRNs is attributed to

20. See Revisions to Rules Regarding the Evaluation of Medical Evidence, *supra* note 3, at 5853.

21. Revisions to Rules, *supra* note 3, at 5852.

22. *Id.* at 5853.

23. *Id.*

24. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *supra* note 5, at 4.

25. The Department of Veterans Affairs (the "VA") draws no such line in their disability analysis. Medical opinions are evaluated when they are "credible and probative," but the VA has not weighed in on whether certain professionals are more persuasive than others. DEPT. OF VETERANS AFFAIRS, M21-1MR, Part III, Subpart iv, Chapter 5, https://view.officeapps.live.com/op/view.aspx?src=https://www.benefits.va.gov/warms/docs/admin21/m21_1/mr/part3/subptiv/ch05/ch05.doc [<https://perma.cc/P2H7-2UVB>].

26. Revisions to Rules Regarding the Evaluation of Medical Evidence, *supra* note 3, at 5845.

the national nursing accreditation agency, and their requirements of education and training.²⁷

If the education level of evaluators is the most important criterion for the persuasiveness of their opinions, there is also an element of pragmatism to the SSA's revisions. The SSA insists that it sought "to align our policies more closely with the ways that people receive healthcare today."²⁸ In a discussion of how APRNs' opinions will henceforth be considered credible, the SSA indicates that "although APRNs are not physicians, including APRNs as AMSs reflects the modern primary healthcare delivery system, including how healthcare is delivered in many rural areas."²⁹

The SSA cited a report published by the Agency for Healthcare Research and Quality in 2012, which noted a concentration of medical doctors in urban areas with patients in rural areas more likely to depend on the services of a NP or PA.³⁰ Acknowledging this distribution means that the SSA's revisions may be *descriptivist* as much as *prescriptivist*. If a growing number of patients spend less time with doctors and more time with other workers, it could position those workers favorably to make compelling findings about those patients' capacity for work. This consideration, though, represents a departure from the SSA's focus on education and credentialing, and prioritizes available data (PA and NP findings) over unavailable data (the absence of rural doctors).

C. *The Right Perspective on Impairment*

Furthermore, the SSA has emphasized the factors of consistency and supportability in ALJs' evaluations of medical opinions, and deemphasized, among other factors, the provider's specialization.³¹ Because of the tremendous growth in specialization and subspecialization of PAs,³² less emphasis on a treatment provider's specialization could sideline their opinions. Since the revision stresses consistency and supportability over specialization, then a key asset in a PA's diagnostic toolbox—her specialization—would be minimized. Correspondingly, the door is further opened to comprehensive examiners, and

27. *Id.* at 5846. The SSA took note of "rigorous national licensing requirements for education, training, certification, and scope of practice that is equivalent to the current and final list of AMSs." *Id.* at 5847.

28. *Id.* at 5856.

29. *Id.* at 5845.

30. Revisions to Rules Regarding the Evaluation of Medical Evidence, *supra* note 3, at 5845 (citing AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, PRIMARY CARE WORKFORCE FACTS AND STATS NO. 3 (January 2012), <https://www.ahrq.gov/sites/default/files/publications/files/pcwork3.pdf> [<https://perma.cc/V6HW-L7GE>]).

31. *Id.* at 5859.

32. See generally Perri Morgan, et al., *Physician Assistant Specialty Choice: Distribution, Salaries, and Comparison with physicians*, 29 JAAPA: JOURNAL OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS 46, 46 (July 2016), https://journals.lww.com/jaapa/fulltext/2016/07000/Physician_assistant_specialty_choice_.8.aspx [<https://perma.cc/5WR8-2CGM>].

non-examining reviewers of medical records, to opine on patients' functional capacity.

The SSA provides an explanation of this shift, and partially acknowledges the trade-off. The SSA deploys the opinions of consultants for a "comprehensive perspective" on a claimant's medical file, a perspective which the SSA says may not be available from a claimant's own treating sources.³³ By this reasoning, a holistic view of disability is attained once the prerogative of treatment is discarded. The revision nudges a PA with specialized knowledge and a personal familiarity with a claimant behind a more anonymous, generalized analyst. Indeed, the SSA cites studies addressing the imminent dissolution of the doctor-patient relationship.³⁴

CONCLUSION

The SSA has revised its rules so that disability claimants' treating doctor cannot offer a decisive opinion as to whether their patient is disabled. Instead, the range of important opinions has expanded to also include treatment providers who are not medical doctors. The specialization and treating relationship of these providers may affect the SSA's assessment of their evidence, but chiefly their evidence will be held to a standard of consistency and supportability.³⁵

In its revision, the agency cited shifts in "modern healthcare delivery" to explain its new rules.³⁶ The broader turn from the pre-eminence of the treating doctor's relationship, as well as the specialized practice of other healthcare workers, means that ALJs can now rely on an increased number of data points in determining disability, whether or not these opinions are from sources who have ever examined the claimant.

Although the number of disability claims to Social Security has decreased each year since 2010, there are still over two million annual claims.³⁷ Increasing the available pool of medical workers permits the SSA to process claims more

33. Revisions to Rules Regarding the Evaluation of Medical Evidence, *supra* note 3, at 5856.

34. *Id.* Sharyn Potter asks whether it should rightfully be termed a "relationship" at all. See Sharyn J. Potter & John B. McKinlay, *From a Relationship to Encounter: An Examination of Longitudinal and Lateral Dimensions in the Doctor-Patient Relationship*, 61 SOC. SCI. & MED. 465, 465 (2005). The SSA also relies on John Saultz's description of anonymous, corporatist health care, even as Saultz finds that interpersonal continuity correlates with improved preventive care and reduced hospitalization. John W. Saultz & Waleed Albedaiwi, *Interpersonal Continuity of Care and Patient Satisfaction: A Critical Review*, 2 ANNALS OF FAM. MED. 445, 445 (Sept./Oct. 2004). The SSA points to consensus that treatment relationships are less significant than they have been in the past, but the agency seems to assume that corporatist models are as shrewd at gathering medical information as treating physicians with personal familiarity with patients.

35. See *supra* note 15 at 5858.

36. Revisions to Rules, see *supra*, note 3, at 5844.

37. See *Disabled worker beneficiary statistics by calendar year, quarter, and month*, SSA OFFICE OF THE CHIEF ACTUARY, <https://www.ssa.gov/oact/STATS/dibStat.html> [<https://perma.cc/8HV7-4VFS>].

quickly, which will be a necessity if proposed budget cuts reduce the SSA's budget by sixteen percent compared to 2010 (after inflation).³⁸ Time will tell whether proof of disability may now rest on a broader range of treatment providers, or whether those providers' findings and opinions can now be marshaled to deny claims more easily.

38. Kathleen Romig, *More Cuts to Social Security Administration Would Further Degrade Service*, CENTER ON BUDGET AND POLICY PRIORITIES, Oct. 6, 2017, <https://www.cbpp.org/research/social-security/more-cuts-to-social-security-administration-funding-would-further-degrade> [<https://perma.cc/EEP7-HD57>].