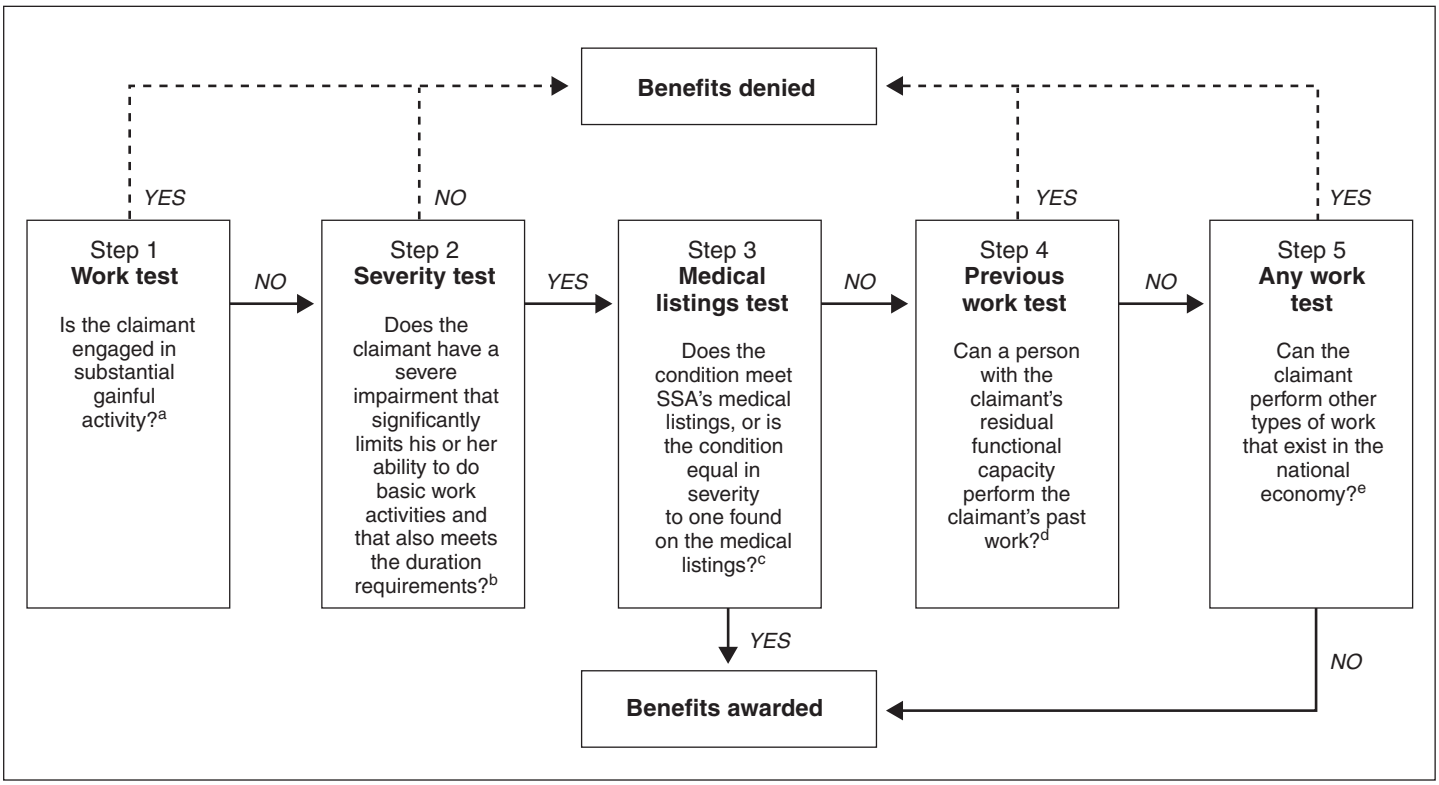
Figure 1: SSA's Five-Step Process for Determining Disability



Source: GAO analysis of SSA data.

[a]In 2008, the substantial gainful activity threshold was $1,570 per month for blind recipients and $940 per month for individuals with other disabilities.

[b]Evidence considered at Step 2 must be primarily medical.

[c]Evidence considered at Step 3 must be primarily medical. Medical listings are federal regulations detailing diagnoses and measures of severity that qualify a claimant as disabled under SSA law. See 20 C.F.R. Part 404, Subpart P, Appendix 1.

[d]Evidence considered at Step 4 may include consideration of nonmedical evidence such as vocational information and work experience.

[e]Evidence considered at Step 5 may include consideration of nonmedical evidence such as vocational information, age, education, and work experience.

Development of Medical Evidence for Initial Determinations

Generally, SSA requires DDSs to develop a complete medical history for each claimant for at least a 12-month period prior to the application. SSA guidance directs DDSs to request records from all providers who have treated or evaluated the claimant during this time period, except those

who treated only ailments clearly unrelated to the claimed impairment.[10] DDSs generally pay providers for records and SSA pays the DDSs to cover these expenses.[11] Each DDS determines its payment rates for medical and other services necessary to make determinations, subject to certain limits.[12] DDSs request laboratory reports, X-rays, doctors' notes, and other information used in assessing the claimant's health and functional capability from many types of providers including: physicians or psychologists; hospitals; community health centers; schools (for child claimants); and Department of Veterans Affairs (VA), military, or prison health care facilities. In addition to medical evidence, DDSs review statements from the claimant or others about the claimant's impairment and ability to perform daily activities. SSA directs DDSs to make "every reasonable effort" to help the claimant obtain medical reports, which SSA defines as one initial medical records request and, if needed, one follow-up request within 10 to 20 days, when providers have not responded, unless experience with a particular provider warrants more time. DDSs allow a minimum of 10 days after the follow-up request for the provider to reply. When records indicate the claimant has been to other medical providers, DDSs also contact those providers for records. Generally records are placed in the claimant's case record.[13]

SSA regulations require that disability determinations place more, and in some cases controlling, weight on the opinions of a claimant's treating

[10]Medical records covering the full year prior to the application generally are not required when claimants reports they became disabled more recently. Certain situations may require medical records from earlier time periods.

[11]According to SSA, federal providers, such as the VA, are not eligible for payments for medical records. Congress authorized SSA to pay for medical records for SSI claims from the program's inception because it was considered unreasonable to expect a claimant to pay for medical evidence for a need-based federal program. In 1980, Congress amended the Social Security Act to also allow payment for medical records under the DI program with the intent to obtain timely medical records and thereby reduce the need to order more expensive consultative exams.

[12]DDS payments for individual medical services are subject to federal or state limits. The DDSs have discretion within the available funding SSA provides them to purchase medical records and consultative exams as is necessary to process their workload target.

[13]As of January 2007, all DDSs were certified for processing initial claims electronically. A key feature is the use of claimant electronic folders. Electronic folders are electronic data repositories that replaced SSA's paper folder system, allowing information to be viewed and shared electronically by all disability processing components regardless of location.

providers.[14] For example, a treating provider's opinion about the nature and severity of the claimant's impairment should generally be given controlling weight where their opinion is well supported by other substantial evidence in a claimant's case record.[15]

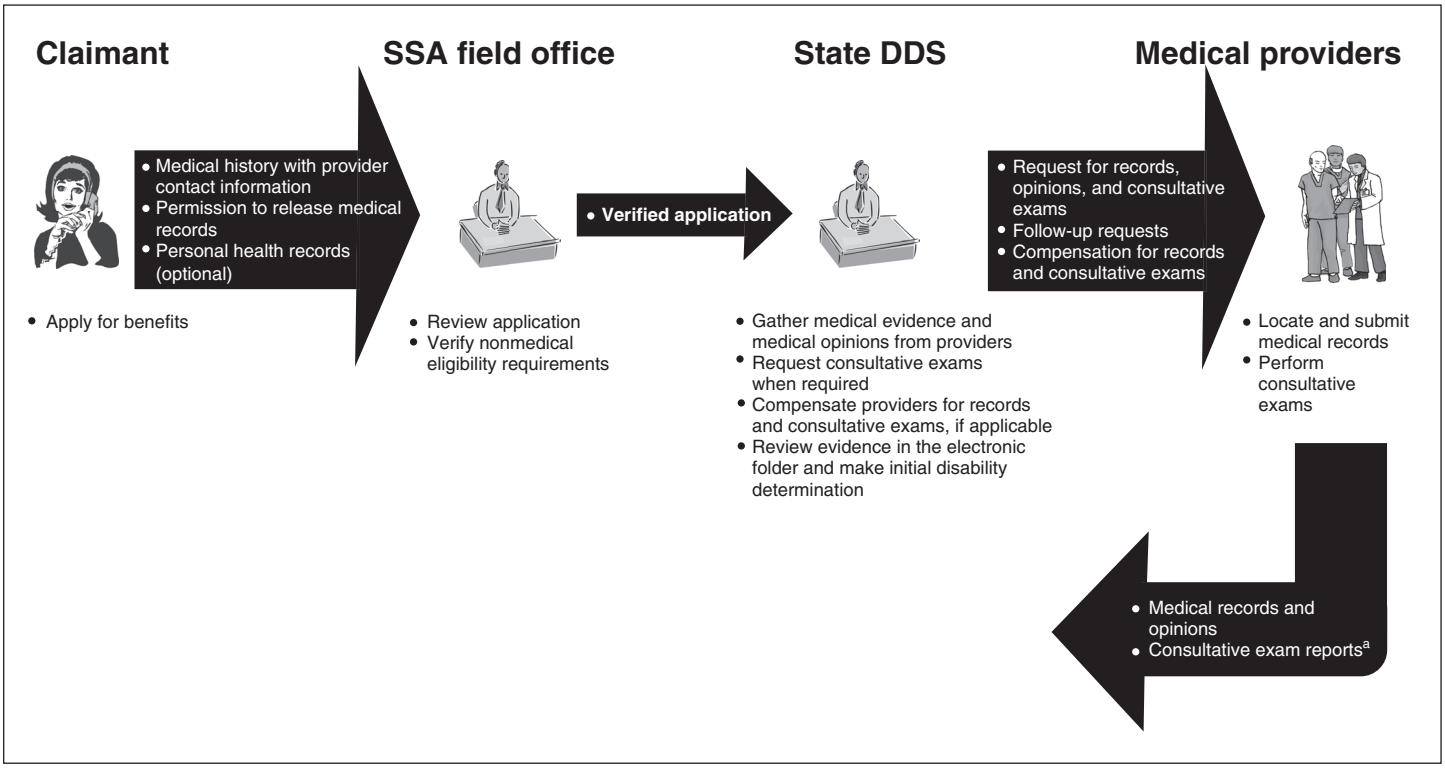
In claims where the gathered medical and nonmedical evidence is insufficient to support a disability determination, DDSs may order consultative exams or tests.[16] DDSs pay providers to perform these examinations and SSA pays them to cover these costs. SSA regulations require that payments to providers for consultative exams not exceed the highest rate paid by federal or other state agencies for the same or similar services. The regulation allows states to determine the rates of payment and, as a result, DDS rates of payment for consultative exams vary nationwide. SSA regulations specify the types of providers who may perform these exams or tests, and require DDSs to recruit, train, and oversee them. SSA regulations also state that the claimant's own provider is generally the preferred source for consultative exams if qualified, equipped, and willing to perform the exams. (See fig. 2.)

[14]In order to establish whether claimants have a medically determinable impairment, SSA and DDSs must have evidence from medical providers who meet the definition of "acceptable medical sources," which generally include physicians, psychologists and, for the limited purpose of documenting a diagnosis within their fields of practice, podiatrists, optometrists, and speech-language pathologists. In this report, use of the term "medical provider" is intended to refer to an acceptable medical source as defined by SSA, and "treating provider" as a claimant's own medical provider as defined by SSA.

[15]The effect of controlling weight is that the DDS may not substitute its judgment for that of the treating provider. According to SSA's regulations, treating providers' opinions are entitled to more weight because those providers are most likely to have long-standing, detailed knowledge of claimants' medical impairments and "may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative exams or brief hospitalizations." 20 C.F.R. §404.1527(d)(2), §416.927(d)(2).

[16]DDSs will not order diagnostic tests that involve significant risk to the claimant.

Figure 2: Medical Evidence Collection for Initial Disability Determinations



Source: GAO analysis of SSA data; images (Art Explosion).

[a]Medical records, opinions, and consultative exams from medical providers are stored in claimants' electronic folder by SSA or a scanning contractor.

To support DDSs' efforts to process claims quickly, SSA has established an expedited process for claims in which a determination of disability is likely. In September 2007, SSA implemented its Quick Disability Determination process nationwide after testing it in the Boston region. This process uses a computer model using certain key terms in the claim file to identify claims for which a decision of disability is likely and medical evidence establishing disability can be easily obtained. DDSs can use expedited processes for these claims; for example, DDS staff in a couple of states we visited explained how they request and receive

medical records for Quick Disability Determination cases by fax.[17] SSA reported, for fiscal year 2007, that the national average processing time for all initial claims was 83 days. By comparison, during the pilot, the Boston region decided Quick Disability Determination claims in an average of 11 days.[18] SSA also has policies to expedite claims involving diseases such as certain types of cancer that are terminal or otherwise so severe that they clearly meet SSA's definition of disability.

SSA performs a quality assurance review of a sample of more than 30,000 DDS decisions each year. SSA assesses the accuracy of the DDSs' determination and the sufficiency of the documentation for the DDSs' compliance with requirements for medical records collection and consultative exams process. Decisional deficiencies occur when a different determination should have been made, and documentation deficiencies occur when additional documentation is necessary in order to make the correct determination. SSA also collects extensive data on spending for consultative exams and requires DDSs to routinely report substantial budget, program operations, and management data to SSA.

Electronic Medical Record Collection

In 2004, President Bush called for widespread adoption of interoperable electronic health records within 10 years and issued an executive order assigning the coordination of the effort to the Department of Health and Human Services.[19] Under the department's leadership, volunteer organizations designated to develop standards for the health care industry have prepared initial certification criteria for health information technology such as electronic patient records and records management systems. As businesses, providers decide when and whether to invest in these certified systems. Another executive order in 2006 directs certain

[17]According to SSA, though DDSs are required to perform expedited development for Quick Disability Determination claims, DDSs may fax requests for medical records for any claim regardless of the priority status of the claim. In addition to manually faxing, the DDSs may use SSA's Electronic Outbound Request (EOR) system to automatically fax the medical evidence request directly from the case processing system instead of printing.

[18]This was the Quick Disability Determination average from the start of the pilot until the preparation of SSA's 2007 Performance and Accountability Report, which was issued Nov. 7, 2007.

[19]Executive Order 13335, *Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator* (Washington, D.C., Apr. 27, 2004).

Table 3.6 —FY 2019 CE Counts and Cost Data[1]

	Annual Number of Cases with at Least One CE[2]	CE Rate[3]	CE Costs[4]	CE Cost per Case[5]
National Total (Disability Determination Services (DDS) + Federal)	1,376,588	33.5%	$345,269,112	$250.8
All DDS	1,374,571	34.1%	$344,793,141	$250.8
Boston Region	45,146	26.1%	$9,968,784	$220.8
Connecticut	9,951	26.5%	$2,175,508	$218.6
Maine	5,612	33.9%	$1,336,818	$238.2
Massachusetts	17,117	22.3%	$3,537,567	$206.7
New Hampshire	5,331	42.0%	$997,077	$187.0
Rhode Island	3,886	28.2%	$981,868	$252.7
Vermont	3,249	35.0%	$939,946	$289.3
New York Region	153,148	51.7%	$35,823,011	$233.9
New Jersey	29,373	34.7%	$7,874,284	$268.1
New York	111,285	51.9%	$25,960,898	$233.3
Puerto Rico	12,490	66.1%	$1,987,829	$159.2
Philadelphia Region	124,594	28.4%	$32,573,173	$261.4
Delaware	2,282	21.4%	$660,566	$289.5
District of Columbia	4,226	16.1%	$1,338,765	$316.8
Maryland	22,583	36.8%	$8,007,452	$354.6
Pennsylvania	62,324	35.8%	$14,140,635	$226.9
Virginia	19,606	16.9%	$5,261,414	$268.4
West Virginia	13,573	36.9%	$3,164,341	$233.1
Atlanta Region	367,889	35.8%	$88,711,404	$241.1
Alabama	34,370	36.3%	$7,491,785	$218.0
Florida	108,555	32.0%	$28,423,173	$261.8
Georgia	54,757	43.4%	$14,920,605	$272.5
Kentucky	33,606	38.4%	$5,702,107	$169.7
Mississippi	25,735	36.2%	$4,499,807	$174.9

[1] Extended Service Team (EST) CE data and costs are built into the State amounts (VA, MS, AR, OK).
[2] Our systems track the number of cases with at least one paid CE, not the total number of CEs ordered and completed for any given case.
[3] CE rate is the number of cases for which at least one CE is ordered and paid compared to the total number of cases. This rate does not reflect the total volume of CEs ordered and paid. Our systems do not include the level of detail to identify if CEs were conducted by the treating medical provider.
[4] CE costs represent costs for all CEs, including if there were more than one CE per case.
[5] CE cost per case represents total CE Costs divided by the number of cases with at least one CE.

	Annual Number of Cases with at Least One CE[2]	CE Rate[3]	CE Costs[4]	CE Cost per Case[5]
North Carolina	49,863	36.7%	$13,439,414	$269.5
South Carolina	24,803	36.0%	$5,269,495	$212.5
Tennessee	36,200	38.1%	$8,965,018	$247.7
Chicago Region	231,339	38.3%	$55,023,814	$237.8
Illinois	48,986	37.2%	$12,101,556	$247.0
Indiana	38,287	41.4%	$8,787,959	$229.5
Michigan	50,123	43.1%	$8,777,681	$175.1
Minnesota	14,779	31.1%	$4,630,474	$313.3
Ohio	55,624	34.7%	$13,745,433	$247.1
Wisconsin	23,540	37.4%	$6,980,711	$296.5
Dallas Region	181,731	29.0%	$44,859,433	$246.8
Arkansas	21,409	26.0%	$4,949,351	$231.2
Louisiana	31,255	37.7%	$6,455,817	$206.6
New Mexico	11,416	45.5%	$2,741,653	$240.2
Oklahoma	24,926	33.2%	$5,955,084	$238.9
Texas	92,725	28.7%	$24,757,528	$267.0
Kansas City Region	50,402	31.2%	$13,421,066	$266.3
Iowa	10,174	26.0%	$2,799,410	$275.2
Kansas	7,207	42.4%	$2,093,953	$290.5
Missouri	26,236	32.0%	$6,464,961	$246.4
Nebraska	6,785	42.4%	$2,062,742	$304.0
Denver Region	29,387	37.8%	$12,065,878	$410.6
Colorado	14,439	37.0%	$6,104,832	$422.8
Montana	2,974	34.3%	$919,206	$309.1
North Dakota	1,466	29.5%	$631,087	$430.5
South Dakota	1,554	23.9%	$709,365	$456.5
Utah	7,404	39.0%	$2,879,273	$388.9
Wyoming	1,550	43.6%	$822,115	$530.4
San Francisco Region	153,174	32.3%	$37,975,541	$247.9
Arizona	24,886	32.9%	$6,424,754	$258.2
California	118,395	31.3%	$28,718,672	$242.6
Hawaii	2,190	16.2%	$916,452	$418.5
Nevada	7,703	30.9%	$1,915,663	$248.7
Seattle Region	37,761	22.8%	$14,371,037	$380.6
Alaska	1,125	24.7%	$670,675	$596.2
Idaho	5,226	20.2%	$1,659,206	$317.5
Oregon	12,095	24.7%	$4,338,443	$358.7
Washington	19,315	24.9%	$7,702,713	$398.8

	Annual Number of Cases with at Least One CE[2]	CE Rate[3]	CE Costs[4]	CE Cost per Case[5]
Federal	2,017	2.3%	$475,971	$236.0

The Division of Disability Determination has scheduled you for an examination with the Industrial Medicine Associates ("IMA"). Please review these questions before the exam.

Please complete this form <u>IMMEDIATELY</u> after your IMA examination.

Your Name: _____

Exam Date: _____

IMA Address: _____

How did you get to the IMA office? _____

Did you have someone go with you to the office? _____

How long did you wait in the waiting room? _____

Did the receptionist ask you to fill out a 2 page form about your medical problems, hospital admissions, medicines, drug use, and activities of daily living? ☐ Yes ☐ No

How many minutes did you actually meet with the doctor?

☐ < 10 min ☐ 10-15 min ☐ 15-20 min ☐ 20-25 min ☐ > 25 min

Did the doctor ask you about your medical conditions?	☐ Yes	☐ No
Did the doctor ask you about your symptoms?	☐ Yes	☐ No
Did the doctor ask if you went to the hospital or saw a doctor?	☐ Yes	☐ No
Did the doctor ask you about your current medications?	☐ Yes	☐ No
Did the doctor ask you about using cigarettes, alcohol, or drugs?	☐ Yes	☐ No
Did the doctor ask you if you live alone or with other people?	☐ Yes	☐ No
Did the doctor ask if you could do certain activities? (shower, dress, cook, clean, shop, and do laundry)	☐ Yes	☐ No
Did the doctor ask if you could do those activities without help?	☐ Yes	☐ No
Did the doctor ask you if you had any hobbies?	☐ Yes	☐ No
Did you feel like the doctor listened to all of your explanations?	☐ Yes	☐ No

Did you go to the office with a cane, walker, or other device? ☐ Yes ☐ No

Was the doctor in the room when you got undressed? ☐ Yes ☐ No

Did you have any problems getting on and off the exam table? ☐ Yes ☐ No

If you sat in a chair, any problems getting up from the chair? ☐ Yes ☐ No

Did the doctor put an object on your chest and ask you to breathe? ☐ Yes ☐ No

Did the doctor check your heartbeat? ☐ Yes ☐ No

Did the doctor test your reflexes (tap knees with a hammer)? ☐ Yes ☐ No

Did the doctor place his hands on any part of your body? ☐ Yes ☐ No

Which parts of the body? **Check all that apply.**

☐ **Head** ☐ **Neck** ☐ **Shoulders** ☐ **Arms**

☐ **Upper Back** ☐ **Lower Back** ☐ **Hips**

☐ **Legs** ☐ **Feet** ☐ **I don't remember**

Did the doctor ask you to lie on your back and lift your legs? ☐ Yes ☐ No

Did the doctor ask you to walk on your heels and toes? ☐ Yes ☐ No

Did the doctor ask you to squat down? ☐ Yes ☐ No

Did the doctor ask you if you had pain doing any of these things? ☐ Yes ☐ No

Did you have problems doing any of the things the doctor asked? ☐ Yes ☐ No

Which things did you have problems doing? Why? _____
_____
_____
_____

Any other issues? _____
_____
_____

Did you need an interpreter? ☐ Yes ☐ No

If yes, did IMA provide an interpreter? _____
If not, who translated for you? _____

The Division of Disability Determination has scheduled you for an examination with the Industrial Medicine Associates ("IMA"). Please review these questions before the exam.

Please complete this form <u>IMMEDIATELY</u> after your IMA examination.

Your Name: _____

Exam Date: _____

IMA Address: _____

How did you get to the IMA office? _____

Did you have someone go with you to the office? _____

How long did you wait in the waiting room? _____

Did the receptionist ask you to fill out a 2 page form about your medical problems, hospital admissions, medicines, drug use, and activities of daily living? ☐ Yes ☐ No

How many minutes did you actually meet with the doctor?

☐ < 10 min ☐ 10-15 min ☐ 15-20 min ☐ 20-25 min ☐ > 25 min

Did the doctor ask you how you got to the examination?	☐ Yes	☐ No
Did the doctor ask you who you lived with?	☐ Yes	☐ No
Did the doctor ask you about your education?	☐ Yes	☐ No
Did the doctor ask you about your work experience?	☐ Yes	☐ No
Did the doctor ask you why you left your last job?	☐ Yes	☐ No
Did the doctor ask you about your psychiatric conditions?	☐ Yes	☐ No
Did the doctor ask you about your symptoms?	☐ Yes	☐ No
Did the doctor ask if you went to the hospital or saw a doctor?	☐ Yes	☐ No
Did the doctor ask you about your current medications?	☐ Yes	☐ No
Did the doctor ask you if you live alone or with other people?	☐ Yes	☐ No
Did you feel like the doctor listened to all of your explanations?	☐ Yes	☐ No

Did the doctor ask what you do during a normal day? ☐ Yes ☐ No

Did the doctor ask if you could do these activities?

☐ dress, bathe, and groom ☐ cook ☐ laundry ☐ shop
☐ manage money ☐ drive ☐ take public transportation
☐ socialize with others ☐ get along with family ☐ hobbies or interests

Did the doctor ask if you could do those activities without help? ☐ Yes ☐ No

What problems did you tell the doctor you had doing those activities?

_____
_____
_____

Did the doctor ask you about any of these depressive symptoms?

☐ depressed mood ☐ loss of interest ☐ appetite problems ☐ sleep disturbance
☐ agitation/retardation ☐ decreased energy ☐ feelings of guilt or worthlessness
☐ difficulty concentrating or thinking ☐ thoughts of death or suicide

Did the doctor ask you about any of these anxiety symptoms?

☐ restlessness ☐ easy fatigue ☐ difficult concentrating ☐ irritability
☐ muscle tension ☐ sleep disturbance ☐ panic attacks ☐ fear of specific things

Did the doctor ask you about any of these PTSD-related symptoms?

☐ exposure to death, injury of violence ☐ intrusive memories, dreams or flashbacks
☐ avoidance ☐ disturbance in mood and behavior ☐ exaggerated startle response

Did the doctor ask you if you knew what day and time it was? ☐ Yes ☐ No

Did the doctor ask you to count by 2s to 20? ☐ Yes ☐ No

Did the doctor ask you to try to make change from a dollar? ☐ Yes ☐ No

Did the doctor ask you to count backwards from 20 by 3s? ☐ Yes ☐ No

Did the doctor tell you 3 things and then ask you to repeat them? ☐ Yes ☐ No

Did the doctor ask you to repeat the 3 things after 5 minutes? ☐ Yes ☐ No

Did you have any problems doing these things? ☐ Yes ☐ No

What problems? _____
_____
_____

CE Report Checklist

**Review each CE report – with the client if appropriate – for inconsistencies, discrepancies, and boiler plate language that does not apply to claimant (e.g. client walks with a cane but report says no assistive devices; report says negative SLR but CL insists this test was not performed).

Note the reported symptoms, functional restrictions, and difficulties with ADLs in the CE report's History section. Compare these with the CE's findings in the medical source statement (MSS). Do they match up? If the MSS findings are milder than the reported symptoms and restrictions, does the CE cite to anything to support the MSS finding?

Note the findings in the CE report's Physical Examination or Psychiatric Examination section. Compare the exam findings with the CE's findings in the MSS. Do they match up? If the MSS findings are milder than the exam findings, does the CE cite to anything to support the MSS finding?

**If the CE's MSS findings do not match up, argue in your brief that the CE's opinion is not supported by, or consistent with, the evidence as required under 20 C.F.R. § 416.920c.

> We will consider the following factors when we consider the medical opinion(s) and prior administrative medical finding(s) in your case:
>
> (1) *Supportability.* The more relevant the objective medical evidence and supporting explanations presented by a medical source are to support his or her medical opinion(s) or prior administrative medical finding(s), the more persuasive the medical opinions or prior administrative medical finding(s) will be.
>
> (2) *Consistency.* The more consistent a medical opinion(s) or prior administrative medical finding(s) is with the evidence from other medical sources and nonmedical sources in the claim, the more persuasive the medical opinion(s) or prior administrative medical finding(s) will be.

The factors of supportability and consistency are the most important factors SSA considers when it determines how persuasive it finds a medical source's medical opinions or prior administrative medical findings to be. Therefore, SSA will explain how it considered the supportability and consistency factors for a medical source's medical opinions or prior administrative medical findings in the determination or decision. *Id.*

**Draft a letter to the ALJ more than 10 days prior to the hearing requesting the ALJ subpoena the CE to testify at the hearing or, in the alternative, send interrogatories to CEs. Include proposed interrogatory questions with your request. Also, ask the ALJ to subpoena the claimant's IMA records (anything used to generate the final CE report including draft reports, completed forms, names of people involved in generating the report, IMA appointment protocols and electronic programs, a copy of the form template used by IMA to generate the CE report, etc.).

> "Medical staff must be made readily available for telephone discussions to clarify or answer questions regarding the report, for occasional educational contracts, and to respond to complaint investigations. On rare occasions, medical staff may be required to testify at the SSA office of Hearings and Appeals."

18-MWSICE-App O, pg 8, #5 at otda.ny.gov/contracts/2018/MWSICE/18-MWSICE-AppO.pdf.

CE Report Language EXAMPLES

B CRITERIA

The claimant's major depressive disorder and GAD exacerbate each other and cause restrictions in functioning which meet the B criteria of listings 12.04 and 12.06, in that she has marked limitations in the following areas of mental functioning: interact with others, concentrate, persist, or maintain pace, and adapt or manage oneself. In October 2016, the claimant's treating psychiatrist, Nora Valencia PMHNP, determined that the claimant has a marked limitation in the ability to maintain social functioning as well as marked deficiencies of concentration, persistence or pace, resulting in failure to complete tasks in a timely manner. Ex. 10F, p. 2. In June 2017, psychiatric CE Dr. Howard opined that the claimant seemed incapable of adequately regulating emotions and did not possess a sense of wellbeing. Ex. 5F, p. 5. Dr. Howard also administered an intelligence evaluation at that time and determined that the claimant had a full scale IQ of 69 (2nd percentile) and that her ability to think, reason and problem solve across all measured dimensions is well below average. Ex. 5F, p. 4. Furthermore, the claimant's difficulty concentrating, as discussed above, demonstrates a marked limitation of her ability to concentrate, persist, or maintain pace. The claimant's difficulties dealing with stress and her social withdrawal indicate a marked limitation in her ability to adapt or manage oneself.

It should be noted that CE Howard appeared to have difficulties distinguishing between the claimant's prior level of functioning and her current level of functioning. At one point he states that there "are no more than mild limits given her employment background" (Ex. 5F, p. 5) but later states that:

> **Again given her background she had the capacity to use reason and judgment in making work related decisions and for 14 years apparently interacted adequately with supervisors and coworkers. Given her current emotional status, that might be a problem. She was capable of sustaining concentration and performing a task at a consistent pace but that was a year and a half ago and her emotional state has deteriorated to a large extent making that problematic. Ex.5F, p.5.**

In fact, in October 2015, the claimant took a medical leave from her work due to the exacerbation of her symptoms and a serious deterioration from prior levels of functioning. Ex. 7F, p. 5.

>> >>>>>>>>>>>>>>>>>>>>>>

PSYCHIATRIC HISTORY

At a psychiatric CE with Dr. Glenn Bromley in August 2016, he reported difficulty falling asleep and frequently waking approximately three to four times a night, weight gain of approximately 20 lbs., dysphoric moods, crying spells, loss of interest, irritability, fatigue and loss of energy, worthlessness, concentration difficulties, social withdrawal, excessive apprehension and worry, restlessness, muscle tension, nightmares at times, flashbacks, hyper-startle response, palpitations, sweating, chest pain, and breathing difficulties. Ex. 3F, p. 3. He reported panic attacks occurring approximately every other day, usually when he was around people. Ex. 3F, p. 4. He stated that he felt scared on crowded buses and had some anxiety when taking public transportation. The claimant and his psychiatric treatment team decided that the claimant should only take public transportation from 10 a.m. to 2 p.m. when public transportation tends to be less crowded. Ex. 3F, p. 5. As of August 3, 2016, the claimant had experienced negative auditory hallucinations two months prior. Ex. 3F, p. 4. The CE opined the claimant was markedly limited in his ability to maintain a regular schedule, relate adequately with others, and appropriately deal with stress. Ex. 3F, p. 6.

It should be noted that the CE improperly evaluated notes written by Dr. Judith Shay, the claimant's treating psychiatrist. He states that "It should be noted from Dr. Shay's records that were provided that, "Voices are better," meaning that the hallucinations have resolved." Ex. 3F, p.

3. Administrative Message 12048, entitled "Policy Reminders for Evaluating Schizophrenia Cases" states, "The term 'stable' in medical evidence is not synonymous with 'asymptomatic,' 'in remission,' or 'not disabled.' Stable may be relative to a particular individual and the chronicity and severity of his or her condition." Similarly, the word "better" is not synonymous with "resolved". Improvements in the claimant's auditory hallucinations are relative to the chronicity and severity of his condition. "Better" could mean, amongst other interpretations, that the auditory hallucinations are less frequent, consist of more positive statements, or are no longer command in nature.

In addition, the CE contradicted himself in his medical source statement. He stated, "Vocationally, he presents with no evidence of limitation in his ability to follow and understand simple directions and instruction, maintain attention and concentration, learn new tasks, and perform complex tasks independently or needing supervision. He presents as moderately impaired in his ability to perform simple tasks independently or needing supervision and make appropriate decisions." Ex. 3F, p. 6. Assuming the claimant is moderately impaired in his ability to make appropriate decisions and perform *simple* tasks independently or needing supervision, then it would stand to reason that he would be similarly limited in his ability to perform *complex* tasks independently.

>> >>>>>>>>>>>>>>>>>>>>>>>

Mental Health History

At a psychiatric consultative exam with Arlene Broska, PhD on May 5, 2016, she reported an increased appetite, weight gain, crying, anxiety, loneliness, and difficulty falling asleep. She was "feeling down every day." She did not want to talk to anyone and at times she did not want to shower. She stated that sometimes she feels like she would like to disappear, but not die. She occasionally wakes up at night because she feels like she cannot breathe. Ex. 4F, p. 2. She stated she is not able to use either hand due to the recent surgery and has a home health aide 7 days a week, 10 hours a day. Ex. 4F, p. 3. The CE found there was evidence of mild to moderate limitation appropriately dealing with stress. *Ibid*. **It should be noted that the CE contradicted herself in the report. In the mental status examination section, she recorded, "Recent and remote memory skills were mildly impaired. She could recall 3/3 objects immediately and 2/3 objects after 5 minutes. She could repeat 4 digits forward and 3 digits backward." *Ibid*. However, in her medical source statement, she stated, "There is no evidence of limitation in attention, concentration, or memory." *Ibid*. Also, during the exam, the claimant reported that she is very forgetful and sometimes her mind goes blank. She forgets what she is saying mid-conversation and cannot remember if she took her medications, how to get places, and which direction to go after leaving a store. Ex. 4F, p. 2. Although the CE opined the claimant's memory is mildly impaired based on a one-time examination, her medical records cover many years and indicate a more severe impairment.**

>> >>>>>>>>>>>>>>>>>>>>>>>

B Criteria

The claimant's major depressive disorder and unspecified mood affective disorder exacerbate each other and cause restrictions in functioning which meet the B criteria of listings 12.03 and 12.04, in that he has marked limitations in interacting with others and concentrating, persisting, or maintaining pace. In September 2016, psychiatric CE Dr. Michael Kushner opined the claimant had moderate to marked limitations in his ability to relate adequately with others and appropriately deal with stress. Ex. 3F, p. 5. In June 2018, Dr. Ting determined he had marked restrictions in his ability to understand, remember, and carry out instructions; respond appropriately to changes in a routine work setting; and interact appropriately with the public, supervisors, and coworkers. Ex. 7F, p. 2-3**. It should be noted that there is an inconsistency in psychiatric CE Dr. John Laurence Miller's report. In the printed psychiatric evaluation section of his report, CE Miller stated, "His ability to interact adequately with supervisors, coworkers, and the public is markedly limited." Ex. 6F, p. 5. On the hand written form, CE Miller indicated he had "moderate" restrictions in his ability to interact with the public,**

supervisors, and coworkers. Ex. 6F, p. 8. Marked limitations are more consistent with evidence of record. His difficulty concentration and his social withdrawal and isolation, as discussed above, further demonstrate marked limitations of his ability to interact with others and to concentrate, persist, or maintain pace.

NEW YORK LEGAL ASSISTANCE GROUP

July 24, 2018 **Subpoena Request**

Office of Hearings Operations
26 Federal Plaza, Room 2909
New York, NY 10278

RE:
SSN:

Dear Judge Vecchio:

I am writing to request that you issue subpoenas to require two witnesses to attend the hearing scheduled for August 7, 2018 and be available for cross-examination. The witnesses are Dr. Shenecia Beecher, the author of Exhibit 3F, and Dr. Allen Meisel, the author of Exhibit 4F. This request is made pursuant to 20 C.F.R. § 416.1450(d).

The subjects about which I would like to question the witnesses fall into three broad categories:

1. Qualifications. This includes the witnesses' education and training, practice experience, and whether they receive any particular instruction from SSA or the state agency in SSA's criteria for determining disability in adults and the terminology SSA typically utilizes in describing degrees of impairment, e.g., mild, moderate, marked, extreme (while there was a time when SSA routinely included in the record statements of the qualifications of consultative examiners, the practice has been largely discontinued). A medical source's professional qualifications and familiarity with SSA's policies and evidentiary requirements are factors the regulations require you to consider when deciding which medical opinion to credit. See 20 C.F.R. § 416.927(c)(5), (6). The present record contains no information on these subjects.

2. Report Contents

For each consultant, I believe that there are subject areas that need to be explored. It is, of course, extremely unlikely that either doctor would have any present recollection of his examination at this point in time. But the questions I propose to ask do not depend upon the witnesses' present recollection of the actual examination, and might nevertheless elicit information that will materially assist you in making your decision.

Dr. Beecher

Dr. Beecher's report, for instance, indicates that the claimant had recent imaging showing a herniated disc. Ex. 3F, p. 1. Dr. Beecher then sent the claimant for an x-ray finding only "degenerative changes." It is not clear from Dr. Beecher's report if he reviewed the critical MRI imaging report that had been performed in April 2016, although it seems likely from his findings that he had not. Also, Dr. Beecher noted that the claimant had some improvement with her mobility secondary to a recent epidural steroid injection in August, but he did not explain whether or not this would cause her to have greater mobility at the current exam than she would be likely to have in the forgoing months. Ex. 3F, p. 1. In fact, the claimant later stated that epidurals only caused relief for a month. Ex. 4F, p. 1. Awareness of these facts might well have altered Dr. Beecher's view of the claimant's functional restrictions.

Dr. Meisel

I have somewhat similar concerns with Dr. Meisel's report. He, too, failed to indicate any review of the April 2016 MRI report or the more recent May 2018 x-ray. Unlike Dr. Beecher, Dr. Meisel did not send the claimant for an x-ray or other imaging of her lumbar spine. I would like to question Dr. Meisel about what strike me as inconsistencies between his diagnoses, on the one hand, and the minimal functional limitations he ascribed to the claimant on the other. He diagnosed her with lumbar back pain secondary to degenerative disc disease and bilateral peroneal palsy but found her able to sit for 8 hours without interruption and to stand and walk for 5 hours without interruption. He also found marked limitations with heavy lifting and carrying but then stated that she could lift and carry 20 pounds continuously. I feel that your ability to accurately assess the persuasiveness of Dr. Meisel's opinion would benefit from allowing me to question him.

3. Report Creation

My third area of concern is with the process by which the reports of consultative examinations are created. The typical examination report gives the impression that the examiner conducts a lengthy interview of the claimant, asks detailed questions about mode of living, daily activities, treatment history, medication use, as well as symptoms, and then writes a detailed, lengthy report based upon the claimant's answers and overall clinical presentation. However, this impression may be far from accurate.

For instance, one thing we know is that IMA physicians have every claimant complete and submit a written questionnaire prior to the consultative examination. A copy of the form currently in use accompanies this letter. The form asks the claimant to describe her medical problems, list any hospital admissions, provide the name and dosage of all medications, give details about alcohol, tobacco, and illegal drug use, and describe a roster of daily activities and ADLs. It is certainly possible, perhaps even likely, that it is this form and not the doctor's conversation with the claimant, that is the source of much of the information contained in the CE report. If this is the case, the report gives a misleading impression of the thoroughness and accuracy of the examination.

Indeed, there may be greater problems than this: I strongly suspect that the examining physician does not even see the claimant's form, and that the information on the form finds its way into the body of the CE report because someone other the examiner drafts the report based on the claimant's form and a form on which the examiner records whatever observations he makes.

My questions for the witnesses would therefore include the following:

1. Does the information contained in your report derive solely from your interview with the patient? Are forms completed by the patient the source of any of the information contained in your report? Are there any other sources of information?

2. Do you ever have the opportunity to review medical records, lab work or imaging provided by the patient's treating providers? If so, are these records provided by the patient or OTDA or both?

3. Do you ever, sometimes, or always have access to forms completed by the patient at the time of your examination?

4. Does anyone other than yourself have any role in the drafting of your report? If so, does that person utilize the form completed by the patient in drafting the report? Does that person utilize any information from you in drafting the report, such as a form on which you have recorded your notes and observations?

5. If no one other than yourself composes the report, in general, how soon after the examination do you compose the report?

6. Does the state agency, or do you, preserve any forms prepared by the patient or by yourself that provide information that goes into your final report?

7. In composing the report, do you rely on any forms completed by the patient, or only on your own notes and observations? In composing the report, do you utilize an electronic or computer program that has default settings for normal findings?

I should add that this third group of questions all go to the reports' "supportability." Not only is this one of the factors you are encouraged to consider under the existing regulations; but under the revised regulations governing cases filed after March 27, 2017, supportability (along with consistency) will be one of two factors deemed "most important" for you to consider. See 20 C.F.R. § 416.920c(b)(2). It will therefore be critical, in future cases, to address the concerns about report creation described above.

If the two witnesses are unavailable for cross-examination, then I ask that you consider, in the alternative, the use of interrogatories to obtain the information. Thank you for considering this request. I hope you will agree with me that the information sought is "reasonably necessary for the full presentation of the case" within the meaning of 20 C.F.R. § 416.1450(d). If you disagree, I respectfully request that your reasons for denying the request are set forth in the record.

Respectfully submitted,

Michelle Spadafore
Supervising Attorney

MCs and PCs

A great mystery revealed….

1

Who *are* these people?

- SSA's medical consultants (MCs) and psychological consultants (PCs)
- Employed by each individual state agency
- MC and PC findings are a recognized type of medical evidence

2

What are they tasked with?

- MCs/PCs may make the determination of disability
- The determination may be made on the MC/PC findings together with a State agency disability examiner
- The State agency disability examiner is tasked with gathering evidence for the record
- 20 CFR § 404.1513a.

3

When are MCs/PCs used?

- For initial and reconsideration determinations

4

What do they look at?

- They look at the medical and nonmedical evidence in the record (*the record so far…*)
- This may include CE evaluation(s)
- This may include medical records obtained or supplied by the claimant

5

What findings do they make?

- The MC/PC findings likely include the following critical conclusions:

- existence and severity of impairment(s);
- existence and severity of symptoms;
- meeting or equaling a listing;
- the RFC;
- the duration requirement is met;

6

Other possible findings

- If there is a failure to follow prescribed treatment
- If there is DAA

7

What does SSA call these conclusions?

- Not medical opinions
- SSA calls them prior administrative medical findings

8

Say what?

- *Prior administrative medical finding.* A prior administrative medical finding is a finding, other than the ultimate determination about whether you are disabled, about a medical issue made by our Federal and State agency medical and psychological consultants at a prior level of review (see § 404.900) in your current claim based on their review of the evidence in your case record

- 20 C.F.R. § 404.1513.

9

Needlessly complicated? Perhaps.

- Even though SSA calls these conclusions prior administrative medical findings…..

- ….the findings are assessed under the same regulation as medical opinions….

- ….and any conclusion made by a single decision maker (SDM) is not a prior administrative medical finding and is not assessed for persuasiveness.

10

Requirement to assess PC and MC

- And now the findings are in the record!
- The ALJ must evaluate the findings:
  - We will articulate in our determination or decision how persuasive we find all of the medical opinions and all of the prior administrative medical findings in your case record.
  - 20 C.F.R. § 404.1520c.

11

No more mystery!

- *Now we know*
  - who the MCs/PCs are
  - what the MCs/PCs do
  - what the ALJs must do with these findings
- So let's take a look as some examples of findings

12

Here it is! Probably in the A exhibits

Disability Determination Explanation

This Disability Determination Explanation is for the *DI* claim at the *Initial* level.

CLAIMANT INFORMATION

CLAIMANT INFORMATION

13

This is a sample signature

None of the ARs considered apply to this claim

REGULATION BASIS CODE (RBC)

Regulation Basis Code:
N32-20CFR416.920(g)-CLAIMANT AGE 18 OR OLDER

PERSONALIZED DISABILITY EXPLANATION (PDE)

PDE Text:
X

SIGNATURES

ADULT MC/PC or SDM Signature

S. Shapiro PhD (38) 05/12/2017

Disability Adjudicator/Examiner Signature:

S. Rajopa 05/12/2017

eCAT version: 10.4.35

14

A sample MDI section

MEDICALLY DETERMINABLE IMPAIRMENTS AND SEVERITY (MDI)

ADULT MEDICALLY DETERMINABLE IMPAIRMENTS (MDI)

Does the individual have one or more medically determinable impairments?
Yes

IMPAIRMENT	PRIORITY	SEVERITY
2950 – Schizophrenia Spectrum and Other Psychotic Disorders	Primary	Severe

15

A sample RFC (the beginning)

RESIDUAL FUNCTIONAL CAPACITY

MENTAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

MRFC1

Indicate whether this Mental Residual Functional Capacity (MRFC) assessment is for:
Current Evaluation

The questions below help determine the individual's ability to perform sustained work activities. However, the actual mental residual functional capacity assessment is recorded in the narrative discussion(s) , which describes how the evidence supports each conclusion. This discussion(s) is documented in the explanatory text boxes following each category of limitation (i.e., understanding and memory, sustained concentration and persistence, social interaction and adaptation). Any other assessment information deemed appropriate may be recorded in the MRFC – Additional Explanation text box.

Does the individual have understanding and memory limitations?
Yes

Rate the individual's understanding and memory limitations:

16

A sample RFC section on concentration

Rate the individual's sustained concentration and persistence limitations:

The ability to carry out very short and simple instructions.
Not significantly limited

The ability to carry out detailed instructions.
Markedly limited

The ability to maintain attention and concentration for extended periods.
Moderately limited

The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.
Moderately limited

The ability to sustain an ordinary routine without special supervision.
Moderately limited

The ability to work in coordination with or in proximity to others without being distracted by them.
Moderately limited

The ability to make simple work-related decisions.
Moderately limited

The ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.
Not significantly limited
Explain in narrative form the sustained concentration and persistence capacities and/or limitations:
see narrative

17

A sample explanation by the PC for the RFC

MRFC - Additional Explanation
clmt alleging schizophrenia seen OP East NY Dx.
MSE intact 9/.14. 11/14. 3/15. 10/16:MSE intact
11/16 Attending social work day program; Reports no A/V H; no sxs of psychosis, fully oriented, easy to engage. MSE intact: 1/19/2017. MSE intact 2/17/2017; 3/29/2017.
Current Medications: Haloperidol 10 mg, benztropine 2 mg, lithium carbonate 300 mg 2 every day.
Single IP in 2008.
Clmt w. dx of schizophrenia (MEr for IP stay not in file) has been extremely stable on medication. ADLs indicated that clmt 'worked for awhile cleaning an office and took care of her nephews for awhile'.
FO:NH NEATLY DRESSED, SHE HAD SOME DIFFICULT ANSWER QUESTIONS AT TIMES SHE REQUESTED HER SISTERS ASSISTANCE FOR CLARITY BUT WAS ABLE TO ANSWER MOST QUESTIONS ON HER OWN. WHEN SHE FIRST CAME IN WANTED SISTER TO HANDLE INTERVIEW WHEN I ASKED HER WHY SHE STATED SHE DIDN'T FEEL LIKE TALKING TODAY.
Clmt would be able to engage in simple basic tasks, given supervision with limited contact w. the general public.

MC/PC or SDM Signature

S. Shapiro PhD (38) 05/12/2017

18

A critical look at prior administrative medical findings

- Is it persuasive?
  - As defined by the regulation: 20 C.F.R. § 404.1520c
- The two most important factors
  - Supportability
  - Consistency

19

Looking at Supportability

Supportability = Look to the Explanation within the findings

Does the MC/PC give an explanation for the findings?

What does the MC/PC include for

Objective medical findings

Supporting explanations

20

Where do I look for supportability?

MRFC – Additional Explanation

clmt alleging schizophrenia seen OP East NY Dx.
MSE intact 9/.14. 11/14. 3/15. 10/16:MSE intact
11/16 Attending social work day program; Reports no A/V H; no sxs of psychosis, fully oriented, easy to engage. MSE intact: 1/19/2017. MSE intact 2/17/2017; 3/29/2017.
Current Medications: Haloperidol 10 mg, benztropine 2 mg, lithium carbonate 300 mg 2 every day.
Single IP in 2008.
Clmt w. dx of schizophrenia (MEr for IP stay not in file) has been extremely stable on medication.
ADLs indicated that clmt 'worked for awhile cleaning an office and took care of her nephews for awhile'.
FO:NH NEATLY DRESSED, SHE HAD SOME DIFFICULT ANSWER QUESTIONS AT TIMES SHE REQUESTED HER SISTERS ASSISTANCE FOR CLARITY BUT WAS ABLE TO ANSWER MOST QUESTIONS ON HER OWN. WHEN SHE FIRST CAME IN WANTED SISTER TO HANDLE INTERVIEW WHEN I ASKED HER WHY SHE STATED SHE DIDN'T FEEL LIKE TALKING TODAY.
Clmt would be able to engage in simple basic tasks, given supervision with limited contact w. the general public.

MC/PC or SDM Signature

S. Shapiro PhD (38) 05/12/2017

21

Looking at consistency?

Consistent = Comparing with other evidence in the record

How does the finding stand up against the rest of the record?

what are the other findings?

what are the other opinions?

consistent with the CE? Treating sources?

22

Another strategy

- The regulations list more than just supportability and consistency as factors
- Under Other Factors, there is a provision that introduces the timing of the findings
- Timing allows you to look at whether the findings are "stale"

23

The timing of the findings

- Other Factors [20 C.F.R. § 404.1520c (C)(5)]:
- *This "other factor" addresses the source's familiarity with the record and program rules*
- [W]e will also consider whether new evidence we receive after the prior administrative medical finding makes the prior administrative medical finding *more or less persuasive*

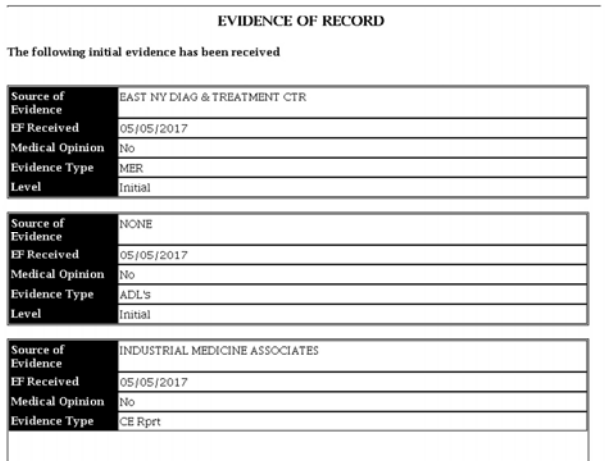
24

How to assess the timing

- *Here, you look at what evidence came in after the findings*
- *Your point here is that the later evidence is filled with details and information that the MC/PC did not have access to at the time*
- *The implication is that the MC/PC would have reached a different conclusion if only he or she had access to all this great, later information!*

25

Where to find evidence about later records and timing?



EVIDENCE OF RECORD

The following initial evidence has been received

Source of Evidence	EAST NY DIAG & TREATMENT CTR
EF Received	05/05/2017
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	NONE
EF Received	05/05/2017
Medical Opinion	No
Evidence Type	ADL's
Level	Initial

Source of Evidence	INDUSTRIAL MEDICINE ASSOCIATES
EF Received	05/05/2017
Medical Opinion	No
Evidence Type	CE Rprt

26

CROSS EXAMINING MEDICAL EXPERTS (MEs)

By Mike Telfer, Senior Attorney
Legal Aid Society of Northeastern NY
(with materials "borrowed" from Kate Callery and Melissa Zeidler)

1

Who are MEs?

- MEs are physicians, mental health professionals, and other medical professionals who provide medical opinions.
- See generally HALLEX I-2-5-32 et. seq

2

Why are MEs called?

- HALLEX I-2-5-34: When to Obtain Medical Expert Opinion
  - ALJ **may** use an ME when ALJ:
    - Determines whether claimant meets a Listing
    - Determines usual dosage and effect of medications and therapies
    - Believes claimant's substance use may be material
    - Believes ME may be able to clarify and explain the evidence or help resolve a conflict because the evidence is contradictory, inconsistent, or confusing
    - Believes ME may be able to suggest additional relevant evidence because there is reasonable doubt about the adequacy of the medical record
    - Believes the ME may be able to assist the ALJ by explaining and assessing the significance of clinical or laboratory findings that are not clear
    - Is determining the claimant's RFC – ALJ may ask the ME to explain or clarify claimant's functional limits and abilities as established by the record
    - Has questions abut the etiology or course of a disease and how it may affect the client's ability to engage in work activity (medically contraindicated activities)
    - Needs opinion regarding onset date
    - Wants an assessment of claimant's failure to follow prescribed treatment

3

Why are MEs called?

- An ALJ will never ask or permit an ME to perform an examination of a claimant
- If an ALJ finds an examination is necessary because there is not enough evidence about an impairment for the ALJ to make a finding, the ALJ will request a CE
- An ME can be scheduled for a 1st hearing, supplemental hearing, or pursuant to a remand order from the Appeals Council (AC)

4

Who cannot be an ME?

- Someone who has treated the claimant in the past or has examined the claimant as a CE, or reviewed the case, such as a DDD non-examining review physician
- ME cannot act in a dual capacity as VE
- ME's specialty should be appropriate to claimant's particular impairment(s)

5

What Does An ME Consider?

- ME must take into consideration the medical findings and signs of record, as well as the claimant's symptoms
- ME should have been sent a complete copy of the medical records in SSA's disability file

6

How do I know an ME will be testifying?

- You will see it in the hearing notice and on your ERE case status list
- The ME's resume will be added to the exhibit file
  - Sometimes right before the hearing so look out for it!

7

Preparing for the ME

- Is there a Medical Source Statement (MSS) from a treating source?
  - If so, what RFC is supported?
  - Is opinion supported by relevant findings?
- What limitations have been identified by the CE?
  - Are CE findings generally consistent with treating source findings?

8

Preparing for the ME

- Ask colleagues about the individual ME and how your individual ALJ acts with them (DAP listserve!)
  - Order of testifying, things to look out for w/ME, how ALJ will interact with ME, etc.
- Know the medical records and academic records (if relevant) and be ready to easily cite to them, e.g., Ex. 9F/45
  - Have an outline of the file that is bolded, etc., with important testing, opinions, lab reports, objective records, subjective statements, diagnoses, etc.
  - Have sample questions that you plan on asking the ME to try to support your ideal limitations

9

Preparing for the ME

- Know which records harm your case and evidence that rebuts the inconsistent evidence
  - Prepare for appeal!
  - I.e, client is reported to be a malinger by one provider as a one-time event. Later records say not malinger.
  - DAA
    - Cite lab reports with clean urine tests and exams w/sobriety
  - Reasons for inconsistent treatment/use of meds
- Draft a prehearing memo
  - Rebutting any harmful evidence
  - Laying out your argument
  - Goal is to get the ME to agree with your best opinions, give a Listing, or give enough of an opinion to knock out work at Steps 4 and 5
    - Once in a while they get access to the briefs!

10

Preparing for the ME

- Common arguments to prepare
  - What limitations will result in a disability finding?
  - How does client meet a Listing?
  - What evidence supports substance abuse not being material?
  - What evidence supports exceptions to non-compliance with treatment/medications? *See* SSR 16-3p.
  - What subjective/objective evidence (MRIs, etc.) supports the limitations?
- Have your relevant Listings printed/on computer along with the vocational definitions (occasional, frequently, mild, moderate, marked, extreme, etc.)

11

Preparing for the ME

- Look up medication in the Physician's Desk Reference (PDR) or another relevant source
  - Why is it prescribed?
  - Side effects?
  - Does the dosage prescribed suggest any thing about severity?

12

Preparing for the ME

- If client has a not-common impairment, if you are not familiar with symptoms, or as a refresher look up the impairment (DSM-5 for mental impairments/Mayo Clinic)
- Identify the objective findings and symptoms related to each diagnosis
  - Have ready definitions of what tests are for if you need to refer to objective testing
- Does the record support claimant's contentions of pain, weakness, fatigue, or any other subjective symptom?

13

Preparing for the ME

- When you prep your client, question your client about things that will line up to your questioning the ME
  - Rebuttal issues to bring up in hearing under oath
    - Non-compliance, DAA, etc.
  - Mental and physical restrictions
  - ADLs

14

Preparing for the ME

- Plan on being surprised
  - You might think you have an idea of what the ME could say
  - There are times the ME will come back unexpectedly with:
    - a horrible RFC assessment
    - an unsupported severity determination
    - or thankfully finds client equals a Listing
  - Your questioning might happen on the fly depending on what the ME testifies but have all the above materials and you should be prepared to some degree
    - Map out possible hypothetical situations if warranted
- Get a good night of sleep
  - These can be a lot of work as we never know what will happen

15

ME Voir Dire

- Stipulate to qualifications as to testifying as an expert, but not to reliability of testimony
  - Protect self for appeal instead of saying no objection to testifying
- Review resume
  - If not there, ask for explanation of credentials

16

How Is The ME Questioned?

- An ME is questioned about the evidence in the record
- The ME is generally present throughout a hearing and is expected to listen to the claimant's testimony and to consider that in evaluating the claim

17

Hearing Order

- However, ME might testify first depending on ALJ preference
  - Know your ALJs!
- If ALJ lets client testify first, elicit helpful testimony that you think ME would want to hear (ie., issues with ADLs, social functioning, concentration, physical limits, etc.)
  - It can make a difference. ME might cite testimony in support.
- Normally ALJ will ask ME for the severe impairments, Listing, any limitations for an RFC, and DAA if applicable
  - Then the ALJ will turn over questioning to you

18

Regulations recap

- Recall how SSA evaluates opinion evidence for persuasiveness:
  - Supportability: is opinion supported by the source's evidence/explanations?
  - Consistency: is the opinion consistent with other evidence/opinions in the record?
  - Relationship with client
    - *Length* of relationship, *frequency* of examinations, *purpose* of treatment, *extent* of treatment, *examining* relationship
  - Specialization
  - Other factors – including familiarity with SSA policies and evidentiary requirements.
- SSA says the 2 most important factors are supportability and consistency

19

Brief Intro Crossing MEs (we'll get into more specifics later)

- What evidence did ME review?
  - Sometimes ME won't have prior file, the E file with academic records, will have missed evidence including IQ scores, or won't realize you submitted new evidence
  - Want to make sure ME reviewed medical source statements
- Which specific exhibits support ME's opinion?
  - Some MEs might give specific pincites others might generally refer to exhibits (Ex. 1F, 2F, etc.)
- Identify treating source opinions
  - Does ME agree?
  - If not, why not?
  - Identify evidence supporting treating source opinions and ask the ME to clarify opinion in light of the evidence

20

After Cross

- Either make a closing argument or request to submit a posthearing brief
- Might make a difference or could prepare early for how your argument to the AC/federal court could look

21

Interrogatories

- If ALJ solicits opinion from ME via interrogatory, consider the following:
  - Respond in writing to the proffer and argue why opinion of ME is not supported
  - Send your own interrogatories to expert
    - Make sure ME reviewed prior files especially when ME is reviewing a remand from federal court where there are 2 combined applications

22

Interrogatories

- Request supplemental hearing to cross the ME
  - Think about whether you want to give the ME the last word about the opinion
  - At least one ME refuses to testify and only does interrogatories
    - Got a new ME to cross at a supplemental
  - In a supplemental your client may have better records/opinions

23

Is the ALJ Bound By The ME?

- No!
- An ME's opinion is not binding on an ALJ
- The ALJ must consider all the evidence, including testimony of an ME and must independently reach a conclusion

24

Practical Situations

- What if the ME testifies the client meets/equals a Listing or testimony supports finding on the Grids based on ALJ's questioning?
  - Typically do not ask any follow up questions
- If ALJ does not indicate agreement with ME, argue finding is consistent with the other opinion/medical evidence
  - If prepared with a closing argument citing the relevant opinion evidence, use it
  - Sometimes closing could be on the spot depending how testimony goes

25

Practical Situations

- What if ME gives an opinion supportive of current disability, but suggests a later onset?
  - Cross the ME for an earlier onset, citing/referring ME to supporting evidence
  - Could mean thousands of dollars in retro benefits

26

Practical Situations

- What happens when ME gives bad testimony off of ALJ's questions?
  - Get ready for some cross examining and to build the record for appeal!
  - ME could get defensive so be ready
  - Use your sample questions/questions should be leading
    - Need a basis for questions, either the testimony, opinions, or the client's records
- Goal is to change minds (not likely but possible!), get a limitation ALJ didn't get the ME to discuss (happens), and build your record for appeal

27

Crossing the ME

- Attack consistency
  - Ask ME if they reviewed opinions?
  - Do you agree those opinions support X limitations?
  - Why not?
    - Prepare to cross on supporting evidence for your opinion.
- Attack Supportability
  - ME might cite random/unfavorable records for opinion
  - Cite favorable records
    - On X date, Dr. X found X. Did you review this record?
    - You noted you reviewed X, X, and X. Doesn't Dr. X's treatment on X support this limitation?
    - Cite treatment from OPWDD, congregate care facilities, job coaches, third party statements as support for clients getting services to see if impacts.

28

Samples

- Taken from Melissa Zeidler:
- If ME thinks substance use is material: Recall SSR 13-2p
  - "I'd like to draw your attention to Ex. 3F at 46 – this record is client's month long psychiatric hospitalization from May 2020. This page shows her toxicology tests were negative and she was still severely symptomatic. Did you consider this period of sobriety when reaching your conclusion?"
  - "I'd like to draw your attention to Ex. 14F at 6 – this is Dr. X's opinion, who has been treating claimant for 5 years, that client's condition does not currently include maladaptive patterns of substance use and her severe limitations remain. Did you consider this opinion in reaching your conclusion?"
  - "I'd like to draw your attention to Ex. 15F at 4 – this is Dr. X's notes that while substances may worsen symptoms, the client's condition is still primarily psychiatrically-based and not the result of substance use. Did you consider this opinion in making your determination?
  - I'd like to draw your attention to Ex. 10E – this is clients IEP from age 9, classifying her as emotionally disturbed and documenting limitations necessitating extra time and separate location for tests and modified promotion criteria. This document is from before Client started using any substances and indicates her condition pre-existed substance use. Were you able to review this record when making your decision?
  - Dr Expert, are you aware that the DSM specifically says that lack of insight and awareness of symptoms is it itself a symptom schizophrenia, and is the most common predictor for higher relapse rates, non compliance with treatment, increased involuntary hospitalizations, and poorer course of illness?

29

Samples

- Continued:
  - There is one psych ME who always diagnoses clients with Adjustment disorder. Adjustment disorder will not win under SSA rules. Be prepared:
    - Draw your attention to Ex 2F – this document is treatment notes from 2016-2019 with psychiatrist Dr. X and Therapist LCSW Y. **Do you agree** they diagnosed severe recurrent depression throughout treatment?
    - Draw your attention to Ex 4F at 6 – the CE report from psychiatrist Dr. A. **Do you agree** Dr. A also diagnosed severe depression?
    - **Would you agree** that all doctors who examined and treated client diagnosed severe depression?

30

Samples

- If ME thinks client can ambulate effectively:
  - "Are you aware that SSA has a particular definition for 'ambulate effectively?'"
  - "Are you aware that SSA explicitly states that the ability to walk independently around one's home without the use of assistive devices does not, in and of itself, constitute effective ambulation?"
  - "Are you aware that SSA considers examples of 'inability to ambulate effectively' to include the inability to walk a block at a reasonable pace on rough or uneven surfaces, and the inability to use standard public transportation, and the inability to climb a few steps at a reasonable pace with the use of a single hand rail?"
  - "Dr. Expert, I understand you may not think Client's cane is necessary, **but do you agree** that Ex. 3F at 2 is a prescription for the cane from her treating doctor from the past 3 years?
    - **This why you need to know SSA terms. Sometimes ME's don't know them and will give you testimony based on what they think a term means rather than what SSA says it means**
    - This questioning assumes that (1) the client testified on Direct to being unable to ambulate effectively in a way that satisfies SSA's definition, and (2) the record documents and supports the conclusions that the client cannot ambulate effectively according to SSA's definition: the client can't take the stairs at the subway station, needs to rest on the stairs in his apartment building, has to rest after walking half a block, uses a medically necessary walker, etc.
    - Recall Mechanics of Representation: have your memo, SSA rules, SSA file, and all necessary documents available during the hearing

31

Practical Situations

- What if ALJ or ME gives a limitation in non-vocational timeframes?
  - i.e, brief and superficial interaction; few changes; brief breaks, etc.
- Ask ME/ALJ to clarify the terms and attack the limits if warranted with the ME cross

32

What's the point of doing all this?

- Your cross is meant to show the ME is giving bad testimony and that the ME's opinion should not be considered persuasive under the factors SSA uses to evaluate opinion evidence.
- Showing the opinion is not persuasive is two-fold:
  - You'll give the ALJ a reason to disregard the ME's opinion and find in favor of your client
  - Even if you don't convince the ALJ, showing the ME's bad testimony is not persuasive is very important for later appeal stages. The ALJ misapplying the factors for weighing opinion evidence is a very good argument on appeal
  - It is much easier to show the ALJ made such an error if you engage in effective cross-examination

33

Appeals and the ME

- Possible ME issues for an appeal
  - Not reviewing a complete record
  - Giving an opinion in an area outside of their field
  - Misstating records (misstatements of the record)
- Was the ME's opinion supported by substantial evidence?
- Did the ALJ commit legal errors in articulating the persuasiveness of the ME's opinion?
  - I.e, you attacked the ME's supportability but the ALJ picked and chose what the ME said at the hearing.
  - Did ALJ rely on ME's erroneous review of the record in assessing RFC?
  - **Did the ALJ fail to articulate the persuasiveness of the ME's opinion or EVEN MENTION IT!**

34

Appeals and the ME

- Not a lot of caselaw on the new regs
- 2 most important factors for argument:
  - **Supportability**: Is opinion supported by the source's evidence?
    - Did the ME properly back up the opinion?
      - Your cross comes in here by you citing evidence attacking the ME's supporting explanations
  - **Consistency**: is the opinion consistent with other evidence/opinions in the record?
    - Your cross about the ME reviewing the other opinions is important here. You lay the foundation for how the ME's opinion is not consistent.

35

Practical Situations

- In intelligence and mental impairment cases ask about occasional reminders throughout the workday and if supported
  - Several VEs have said it eliminates work
  - Make sure ME reviewed all IQ scores and academic records!
- If ME gives barely any limitations, ask if ME agrees with limitations given by treating providers
  - Chance ME could have overlooked stating these opinions

36

Practical Situations

- If ME gives B criteria limitations (concentrating, persisting, or maintaining pace, etc.) but doesn't give limitations in accordance with those, based on your evidence consider giving limitations and ask if limitations consistent
  - Know your opinions and the strength of your case. You might have an old CE in the file as your only opinion so you need the ME to give a credible opinion for the win.
  - You testified to moderate concentrating, persistence, or maintaining pace but didn't give a limitation for that restriction. Would it be consistent with your opinion that the claimant would require occasional reminders throughout the workday?
  - Given the evidence and your opinion about interacting with others, is a limitation that the claimant is to have no contact w/public or coworkers supported?
  - Goal is to knock the RFC down as much as possible.

37

Practical Situations

- ME might not give absences or off task opinion
  - Ask about it while reading the room
  - It's a risk as you might get a limitation you have to rebut
  - Given X opinions and evidence, do you agree a limitation that the claimant would be off task at least 15% of an 8-hour workday is supported?
- Make sure you know the impairments the ME bases their limitations on
  - Could be that their expertise is only limited to one severe impairment and are not considering client's other impairments
    - Ex., ME is orthopedic doctor but is not considering effect of colitis or migraines on client's limitations

38

Practical Situations

- Objecting to ME's qualifications?
  - Might not get far unless the ME's expertise not relevant to case:
    - pediatrician testifying in orthopedic case or orthopedic for psych case
  - Has ME's license been revoked?
- Does the ME prescribe meds and are they qualified to know about side effects?

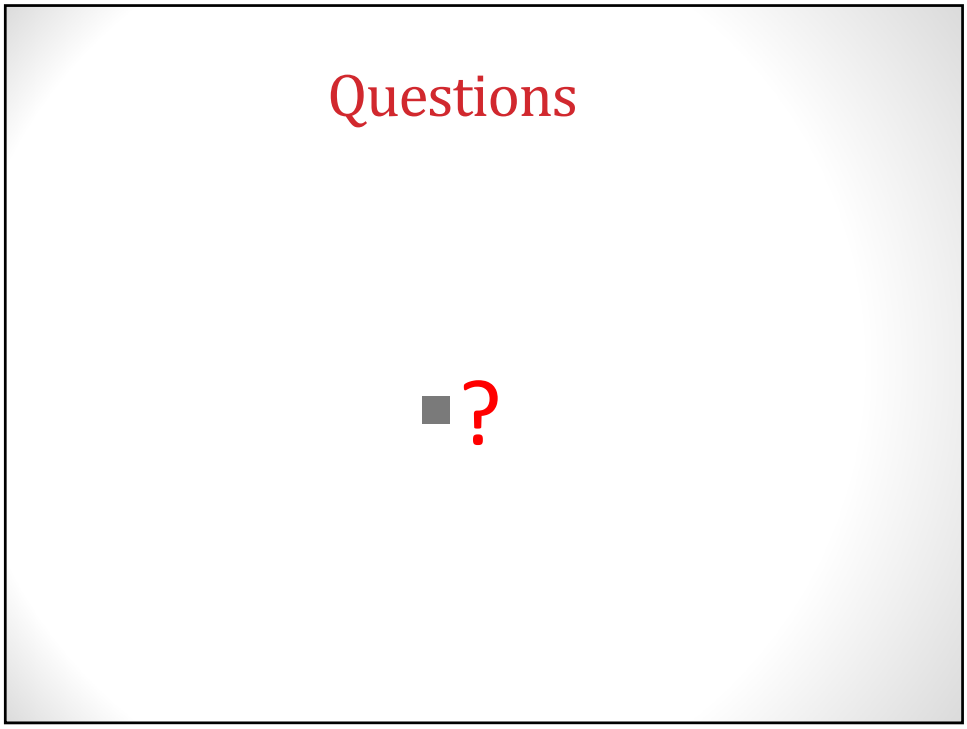
39

Practical Situations

- Look up social media/caselaw
  - Might find bias (but extremely rare)
  - Prior testimony in cases
- Check ME credentials
  - Has the ME ever been sanctioned or under investigation?
  - Does the ME have an active practice treating patients?
    - Does the ME have a website?
- Keep an internal database about MEs
  - How they testify, things other attorneys have said about them, whatever else you want to note for future use

40

Questions



41