

VIA FAX AND EMAIL
December 28, 2007

Commissioner of Social Security
P.O. Box 17703
Baltimore, MD 21235-7703

FAX (410) 966-2830

Re: Docket No. SSA-2007-0044
Comments to proposed regulatory changes

Dear Commissioner:

I have been practicing law for over 26 years, including Social Security Disability and SSI cases from the beginning. Since I went into solo practice 15+ years ago, this has become my main area of practice. I have been a sustaining member of the National Organization of Social Security Claimants' Representatives (NOSSCR) for about 12 years. Please consider the following suggestions regarding the proposed regulatory changes set forth at 72 FR 61218 et seq.:

1. Barring submission of evidence at any stage of the process (e.g., five days before the hearing, or at the Appeals Council or Review Board level), even with the limited exceptions proposed, should not be enacted. In the alternative, any such time limits should include a "good cause" exception, broadly to be construed, with any enumerated grounds being by way of example only, and not exclusive. Reopening based on new and material evidence should similarly be preserved. Record closure is likely to cause unjust denials of benefits to disabled people for several reasons:

a. Delays in diagnosis. It is not unusual for symptoms to be present long before a physician or other health professional pinpoints their cause. This is true even among people who have health insurance and access to treatment. But see b, below.

Example: Claimant had lost most functional use of her dominant arm and hand. As of the time of the first hearing, a neurologist attributed her problems to a tremor of unclear etiology. ALJ denied the claim and a request for review ensued, which was based, inter alia, on the ALJ's failure to consider

Commissioner, SSA

Re: Docket No. SSA-2007-0044

Comments to proposed regulatory changes

December 28, 2007

Page 2

various pieces of medical evidence including a psychological report, an orthopaedic report, and a videotape of the neurologist's exam. I also raised points of legal error. The case was remanded by the Appeals Council. Meanwhile, the claimant consulted an infectious disease specialist who performed more extensive laboratory tests concerning what he suspected were sequelae of a tick bite exposure several years prior. (Claimant had been diagnosed with Lyme's Disease shortly after the original exposure, had undergone a course of antibiotic treatment at that time, and had thought that the condition was resolved.) The later testing was positive for a similar but different parasite, which explained the resurgence of symptoms. Antibiotics were again administered, but permanent damage had already been done. The ALJ was happy to award benefits on remand. The new evidence was significant to the ALJ's decision. This claimant was a lady who had access not only to doctors, but to acclaimed specialists; yet, the primary cause of her disability took years to discover.

b. Lack of access to health care. Many claimants have no health insurance and no regular doctor, some are dependent upon public clinics and some have nothing but the emergency room available to them. Lack of a diagnosis, delayed diagnosis, inaccurate diagnosis and incomplete diagnoses are legion among these people. If a condition is even recognized by a treatment provider (see "a" above), it is often far more difficult to get an explanation of the functional implications of it from a busy clinic doctor than from a private physician. Coordination among providers for treatment purposes, as well as to demonstrate the combined effects of multiple impairments, is even harder to get. Consultative evaluations, even the legitimate ones, rarely dig deeply enough to be of use in this regard.

Example: While incarcerated several years ago, claimant underwent a pap smear which showed moderate squamous hyperplasia. She was told to have a colposcopy upon her release; it was not done in prison, supposedly because release was imminent. Claimant has no access to regular treatment because she is "categorically" ineligible for Medicaid, so there has been no colposcopy nor other follow-up except E/R visits at which the claimant is given painkillers and told see a gynecologist which she doesn't have. The claimant's menses ceased several years ago, but she experiences abdominal pain, cramping and bleeding.

Commissioner, SSA
Re: Docket No. SSA-2007-0044
Comments to proposed regulatory changes
December 28, 2007
Page 3

Is it cancer?

c. HIPAA practice among healthcare providers and record copying services. We are supposed to receive a response to a request for information within 30 days. The provider or its staff usually claims they received the request between Day 5 and Day 10, pushing our response receipt to somewhere around Day 40. That response is often not copies of records, but simply a form letter demanding that we use their entity's special HIPAA form, or a form letter insisting that some technical requirement on the form was not met. The claimant, who does not necessarily live within 20 miles of the representative's office, must be contacted to get the paperwork redone. Some claimants read and write; some have a phone or someone to take phone messages for them; some answer the phone or have someone who does; some live at the address where they receive mail; some respond timely to mail (whether in English or some other language); however, many claimants are challenged in one or more of these respects. See also d and e, below.

Processing time after re-submission of the paperwork depends on whether the provider or its records copying personnel or copy service choose to associate the re-submission with the initial request, which they deem an act of grace on their part. The Commissioner's proposed extension of the lead time before a hearing from 20 days to 75 may help alleviate this problem to some extent, but not entirely. Ninety days might be better, but there will always be issues of developments which surface between the issuance of the notice and the hearing date.

d. Mental impairments. Time bars which can only be lifted based upon an exception to the effect that one's physical or mental impairment prevented one from timely compliance, though admittedly sometimes helpful, can also create a Catch-22. Under the proposed scheme, the same evidence which the claimant needs to prove disability may be needed to prove the exception to get in the door to prove disability.

Also, the link between a mental impairment and the inability to follow through, whether on obtaining evidence or on performing other tasks, can be quite subtle. For example, in traumatic brain injury cases, a claimant can score high on multiple

Commissioner, SSA

Re: Docket No. SSA-2007-0044

Comments to proposed regulatory changes

December 28, 2007

Page 4

neuropsychological indices based on tests administered in a controlled examination setting, yet be unable to stay on task for half an hour unsupervised, or to remain on topic for ten minutes of conversation. Hints may appear in the testing in the form of isolated low scores out of sync with the remaining results, but the full flavor of the limitations becomes apparent only in meeting the claimant (for the ALJ, at the hearing) and, often, with the assistance of testimony from family or friends.

Another significant issue in mental impairment cases (e.g., traumatic brain injury, psychosis) is denial or "lack of insight", another Catch-22: The impairment itself often prevents the claimant from acknowledging that he or she has a problem in the first instance; professional help may only be sought after years of urging by the spouse or family, or when a crisis triggers intervention in the form of arrest or involuntary hospitalization. The condition itself, ironically, generates the delays in diagnosis and treatment as well as the lack of follow-through in the case. I had a recent TBI case where an application filed at the claimant's wife's insistence was dropped after the initial denial, because the claimant was in "denial" about having brain damage, as frequently occurs in these cases. A new application was filed much later (after the now ex-wife had instituted divorce proceedings) at which point, and with the help of a cognitive rehab program, the claimant gradually began to recognize that he might actually have a problem. In cases such as this, justice can only be done if the opportunity to reopen the prior application remains available.

e. Unrepresented claimants. The unrepresented, unsophisticated claimant has difficulty negotiating the system even in its present incarnation. The proposed changes, if enacted, will be experienced as a series of booby traps and will likely generate many unjust denials of benefits.

Then there are the claimants who begin the process unrepresented, but later seek representation. (I take cases from the time of initial application as well as later in the process; not all representatives do this.) Some claimants believe that

Commissioner, SSA

Re: Docket No. SSA-2007-0044

Comments to proposed regulatory changes

December 28, 2007

Page 5

they have to pay an attorney up front, recitations in SSA's correspondence to the contrary (which they may not be able to read or, if able to read, may not understand) notwithstanding; hence, they do not seek representation even to the day that they are standing before the ALJ. Many, many claimants believe that the time to get a lawyer is when it is time to "go to court"-- i.e., two weeks or less before the hearing.

Under the proposed rules, an attorney who insists on being able to provide meaningful, quality representation (or who simply does not wish to risk a malpractice suit) would be likely to refuse to accept cases close to a scheduled hearing date, because the record is about to be slammed shut, and the attorney has no way of knowing what evidence is or is not contained in it.

To pair closure of the record with a rule which forbids objecting to the time or place of a hearing after 30 days from the hearing notice would create an impossible dilemma for a representative who is approached late in the game. Responsible representatives coming late into the process need to be able freely to seek adjournments and freely to seek to have the record held open for additional evidence, or we cannot in good conscience accept representation of claimants who have scheduled hearing dates. These cases are likely to involve the least sophisticated people and the most-poorly-functioning people.

In short, the proposed regulatory changes pertaining to time-barring of evidence and inflexibility in scheduling are likely not only to ensnare the unrepresented, but also to have the possibly unintended but disastrous effect of discouraging representation where it is most needed to attain a fair process and a just result.

f. Closing the record, whether five days before the hearing or at the Appeals Council or "Review Board" level, would eviscerate and belie the ALJ's duty to develop the record, an essential element of the non-adversarial process which must be preserved. Development of the record on remand is often the only way to rectify ALJ error and obtain a fair result. Instead of looking for ways to foreclose the claimant and excuses to block

Commissioner, SSA
Re: Docket No. SSA-2007-0044
Comments to proposed regulatory changes
December 28, 2007
Page 6

evidence and deny cases, scrutiny should be directed to making sure that the ALJ's role in the process is proactive and meaningful. This would be a better way to insure that the ALJ decision comes out right the first time. See Point 3, below.

If what is truly desired is that the record before the ALJ be as complete as possible, it would be helpful if either the local office or ODAR would send to the representative a copy of the complete documentary file (whether paper or on disc) as soon as the hearing request is filed at the DO or received at ODAR. Doing this before the file is "pulled" for hearing admittedly adds a clerical step to the process, but this would tell the representative what is (and is not) in the record earlier, thus facilitating more evidentiary development sooner.

I used to visit the DO at the time of submitting an appeal and copy the entire paper file. In recent years, I have received less cooperation from some of the district offices on this. Sometimes my requests are ignored. Sometimes the DO Manager cannot dedicate staff to babysit for me while I copy the file, due to the hiring freeze. I have also gone to ODAR to copy paper files, but frankly, competition for the single copier in ODAR's waiting area (either Newark or Voorhees) made this impractical to do on a regular basis. When I obtain a copy after the file is pulled for hearing, by the time I receive that copy, the hearing date is sometimes almost upon us.

We need a freely available, routine practice which gives the whole file to the representative early in the process, and repeatedly at each stage of the case if necessary, not only when the case is about to go to hearing. If that were done, I believe that many of the delays in submission of existing or obtainable evidence would disappear without enacting any preclusive regulatory changes.

2. The proposal to require a claimant to list medically determinable impairments demands a level of expertise that many claimants and even many representatives do not possess. It is truly an insidious proposition. It potentially invites gamesmanship and hairsplitting. The idea also poses many of the

Commissioner, SSA
Re: Docket No. SSA-2007-0044
Comments to proposed regulatory changes
December 28, 2007
Page 7

same problems posed by the proposed time-barring of evidence. It can be expected to generate many denials which may look good on paper while embodying monstrous injustice. See also Point 1.

Delayed diagnosis is a big issue here, but by no means the only one. I estimate, in my own practice, that the claimant turns out to be disabled, or the case provable, on a basis other than one initially alleged by the claimant to me, in perhaps 20% of cases. Where a claimant is disabled due to multiple causes, the ones the claimant personally experiences as important are not always the ones which satisfy the legal standards.

Example: Claimant was dying of cancer when she retained me. She had a remote date last insured and the cancer was diagnosed after her insured status expired. At the time this case was adjudicated, we had a Listing for obesity. The claimant's weight met the obesity standard and she satisfied the additional criterion of the Listing based on arthritis in her knees. Both criteria were documented in her primary doctor's records as of a time prior to the DLI. The ALJ (who has since himself died of cancer) awarded benefits, based (on paper) on the obesity Listing, but truthfully, because he knew the claimant was terminally ill. The claimant would never have dreamed that she would get disability not because she was dying of cancer, but on the basis that she was fat. The claimant did not even necessarily think of obesity as a "medically determinable impairment".

To foreclose an award of benefits grounded on proof of impairments not alleged would utterly ensnare unrepresented claimants and encourage ALJs to abdicate their duty to develop the record. It would introduce adversarial elements into the process, without affording any compensating protections.

Any enumeration of impairments should be voluntary, should be used for convenience only, non-binding, and with no preclusive effect whatsoever.

3. As to the proposal regarding prehearing conferences, I believe that these may be very helpful, and they should be used as an opportunity to involve the ALJ in obtaining evidence (via

Commissioner, SSA

Re: Docket No. SSA-2007-0044

Comments to proposed regulatory changes

December 28, 2007

Page 8

subpoena when necessary or appropriate). They could also afford the claimant and the representative, and the ALJ, an opportunity to find out from one another about any factors which may have been overlooked by either side and to focus the issues.

However, in my opinion, participation in a prehearing conference, in disability cases, should be voluntary and not mandatory. Under no circumstances should the failure to participate in a prehearing conference be used as a basis to dismiss the request for hearing. It's difficult enough for many claimants to attend the hearing itself, not only due to their disability, their homelessness, their hospitalizations and the like, but also due to financial and transportation issues. Many claimants have no telephone, limited access to a telephone, or a telephone which gets disconnected (or cellphone minutes which expire) from time to time when the money runs out. The threat of dismissal also invites opportunism by hostile ALJs, not only against ill and impoverished claimants, but also against solo attorneys (such as myself) and small firms, who are always juggling competing scheduling demands and may not be able to participate routinely in multiple proceedings for the same disability case or to appear, even by telephone, on short notice. Such summary dismissals may inflate the ALJ's case disposition statistics, but at the expense of justice to claimants.

4. The proposal to limit new evidence, at any point, to evidence which is likely "alone or when considered with the other evidence of record" to change the outcome of the decision, has inherent pitfalls. It assumes that the decisionmaker has the expertise to determine the significance of the evidence without explanation from the source or expert testimony, which may not be the case. It would not permit the admission of evidence which may point to a potentially significant and limiting impairment, but whose significance or impact cannot be fully appreciated without further work-up. The follow-up evaluation, diagnostic testing, expert elucidation or combination of these might unite pieces of the puzzle previously unexplained; it would not necessarily relate only to the claimant's current status. See Point 1a above. Foreclosing evidence which does not sway the

Commissioner, SSA

Re: Docket No. SSA-2007-0044

Comments to proposed regulatory changes

December 28, 2007

Page 9

case either by itself or together with the existing record would force the decisionmaker to turn a claimant away, precisely at the point when the potential merit of the case and the need for further development of the record becomes most apparent.

The current requirement at the Appeals Council level, that any additional evidence submitted be new and material to the time period at issue, is quite stringent enough, and allows sufficient flexibility for any necessary additional development, either by the Appeals Council itself or on remand by the ALJ.

More generally, I think the Commissioner's expressed concern that the Appeals Council as currently constituted may be uselessly remanding cases where the claimant is not disabled, based on mere technical deficiencies, is specious. Quite the contrary, reluctance by the Appeals Council to disturb really bad ALJ decisions results in federal court appeals, remands and EAJA fees. Tightening the noose at the post-ALJ administrative review level is likely to generate more federal court appeals and, in the interim, more homelessness and death among the disabled.

5. I question the requirement that a claimant, or the person applying on the claimant's behalf, provide both his or her own Social Security Number and that of the wageearner, on any form. Only one of these may be available to the claimant or the person applying. In my opinion, if enough other identifying information and documentation is provided, SSA should supply the missing SSN and process the claim.

6. With respect to 404.939: The claimant or representative should be able to object to the time and place of the hearing beyond the 30 days, for good cause shown. People who are poor and sick go into the hospital. They get evicted and have to move. They wind up staying with relatives in another state. Some spend long periods of time living as transients. This is yet another proposal which would unjustly elevate administrative convenience over client service. Adjournment requests should be freely granted as well.

Commissioner, SSA

Re: Docket No. SSA-2007-0044

Comments to proposed regulatory changes

December 28, 2007

Page 10

7. The proposed changes as a whole are unlikely to generate significant time or cost savings in the long run, but will more likely result in increased federal court litigation over technicalities, necessitate multiple applications simultaneously consuming administrative resources (at different stages) for the same claimant, engender unnecessary procedural wrangling, and ultimately cause unjust denials, and increased poverty, homelessness and death among the disabled.

The main "benefit" that I see from the proposed changes is that ALJs would have the comfort of knowing that the record will usually be frozen when they hold their hearing or make their decision. They will not "suffer" the annoyance of having to see a case again to consider evidence they may not have seen before. That tidies up the procedure a bit. However, the Social Security Act is not common law and this is not ordinary litigation; it is a remedial social program built from contributions of wageearners for the protection of disabled people. People's lives and medical conditions are not static and the search for diagnosis and struggle for treatment are not static. Claimants are not cannon fodder created for the purpose of justifying case statistics for ALJs or hearing offices.

The proposed regulations are a poor substitute for the real reforms which are necessary and would truly help to eliminate backlogs without unfairly denying benefits to disabled people. Those real reforms should include, for example:

I. SSA is understaffed. We need more ALJs, of course, but the District Offices are also terribly squeezed. Conscientious and experienced personnel in the DO s as well as the hearing offices daily encounter nearly insurmountable obstacles in providing needed services to the claimants and to the public. They are swamped. Funding is needed to hire necessary personnel.

II. Evidence developed by the State agencies at the initial application and reconsideration levels, as well as at the hearing level, should routinely be made available to claimants and their representatives. Instead, State agency claims adjudicators take it upon themselves to refuse representatives access to consultative evaluation reports and other evidence they obtain. They at times obstruct rather than facilitate cooperative claim development. They sometimes refuse to

Commissioner, SSA
Re: Docket No. SSA-2007-0044
Comments to proposed regulatory changes
December 28, 2007
Page 11

acknowledge the representative's right to have access to evidence and to participate in the case. If the claims adjudicators were more cooperative and the representatives could see the record before the claim is denied, perhaps perceived deficiencies could be rectified and there might not need to be an appeal in some cases.

III. The State agencies, in many cases, are still applying a Listings-only standard, whether overtly or covertly. Moreover, to the extent that RFCs are employed, many times the limitations noted grossly understate what's in the evidence. Although some CE s are legitimate, many are, frankly, a sham. Intellectually honest evaluation of the claimants' conditions and limitations prior to the hearing level would result in more cases getting paid sooner. Someone should disabuse the State agency personnel, lay and expert, and their consultative contractors, of the notion that they are being paid to deny claims and that their relationship to the claimant and the representative is an adversarial one.

IV. More varieties of testing should be made available on a consultative basis, when appropriate. A few examples would include MRIs, neuropsychiatric (including IQ) testing, and specialized blood tests. Perhaps this sounds expensive, but it is probably less expensive and more fair than a protracted adjudication process which fails to discover the truth.

In short, we need more personnel and resources and a sincere effort to do the job right, not a series of procedural snares designed to eliminate claims without taking care of the claimants. Thank you for your consideration.

Respectfully submitted,

s/Erica J. Mandell
Erica J. Mandell
Attorney at Law
46 Bayard Street, Suite 306
New Brunswick, NJ 08901
(732) 220-8565 phone
(732) 448-1378 fax
ejmandell@verizon.net