

**NATIONAL ORGANIZATION OF
SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES
(NOSSCR)**

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Executive Director
Barbara Silverstone

August 3, 2021

Office of Regulations and Reports Clearance
Social Security Administration
3100 West High Rise Building
6401 Security Boulevard
Baltimore, Maryland 21235-6401

RE: Docket No. SSA-2021-0010
Submitted via [regulations.gov](https://www.regulations.gov)

Dear Madam or Sir,

These comments are submitted on behalf of the National Organization of Social Security Claimants' Representatives (NOSSCR), a specialized bar association for attorneys and advocates who represent Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) claimants throughout the adjudication process and in federal court.

The Temporary Final Rule (TFR) on "Flexibility in Evaluating "Close Proximity of Time" in the context of COVID-19 Related Barriers to Healthcare" will be useful to many Social Security disability claimants. We appreciate SSA's decision to institute this TFR.

We encourage SSA to make this TFR permanent. Before the Covid-19 pandemic, disability claimants often experienced difficulty in documenting medical criteria in medical records within a four-month period. As NOSSCR stated in comments on the Notice of Proposed Rulemaking about revised musculoskeletal listings, when a criterion appears in the medical record is not always, and should not be considered as, the time when the criterion actually began to happen. Even without the additional challenges caused by the pandemic, it can take more than four months to document all of the criteria included in a listing.

For example, listing 1.15 requires claimants to demonstrate symptoms, signs, imaging, and physical limitations. A claimant who has a symptom (pain, paresthesia, or muscle fatigue) is unlikely to contact his doctor the first day this symptom occurs. Once a doctor is contacted, it can be weeks until an appointment is available. It is possible that a doctor could document signs at that first appointment, such as muscle weakness or decreased reflexes, but it is also possible that the provider does not record such findings and simply directs first-line treatments such as over-the-counter painkillers, exercise, or warm compresses, or refers the patient to a specialist or

physical therapy. It is unlikely that a doctor would perform electrodiagnostic testing or other ways of documenting signs on an initial visit. In those scenarios, the documentation of signs could occur significantly after the documentation of symptoms, which itself could be long after the symptoms first occurred. Similarly, it is highly unlikely that imaging would occur at an initial visit: in a survey of family medicine doctors, only 26.1% had x-ray machines in their practice,¹ and not every provider who has such a machine would use it at an initial visit with a presenting complaint of back pain, paresthesia, or muscle fatigue. Far fewer providers would have access to MRIs, CT scans, or other types of imaging, requiring patients to visit a hospital or specialized radiology practice. Imaging results, therefore, could be long after signs and symptoms are documented.² The final portion of the listing criteria, documenting a combination of the need to use an assistive device and inability to use one or both upper extremities,³ could easily occur more than four months after documenting symptoms—and more than four months after symptoms and functional limitations first occurred. Many providers are likely to wait through several specialist visits or treatment modalities (such as painkillers, massage, physical therapy, etc.) before determining that an assistive device is needed.

Delays in accessing these services—which are greater in people who have public health insurance or no health insurance⁴—could easily extend documentation of the listing criteria beyond SSA’s 4-month window, and disability claimants frequently use Medicaid or lack health insurance.⁵ Although the standard of care would allow all of the listing criteria to be documented within a 4-month period, the need to save money for treatments, difficulty getting or traveling to appointments, the need for insurance preauthorization, additional challenges posed by other impairments, lack of medical providers in certain parts of the country, wait times for consultative examinations to be ordered and scheduled when treating providers are nonexistent or have not documented the listing criteria, and other sources of delay mean that the standard of care is not always met. This unfortunate fact should not be compounded by using it as a reason to deny disability benefits.

The barriers claimants face in documenting their disabilities existed before Covid-19 and will not go away when the public health emergency ends. Making the TFR permanent would better accommodate how disability claimants interact with the medical system, and would better reflect an increasing trend toward telemedicine (which, as the TFR notes, limits providers’ ability to perform certain tests or record certain signs) that is likely to continue even after the public health emergency ends. Requiring the listing criteria to be documented within a 12-month period rather than a 4-month period is more in keeping with the Social Security Act’s 12-month durational requirement and will allow claims to be awarded more efficiently at step 3 of the sequential

¹ <https://www.aafp.org/about/policies/all/radiology-position-paper.html>

² Wait times for MRIs are often 2-4 weeks; see <https://cornellsun.com/2018/02/08/mri-wait-times-must-be-shortened-to-improve-health-care-cornell-researchers-say/>

³ NOSSCR opposed the inclusion of the documented need for assistive device and/or inability to use upper extremities in when listing 1.15 and other listings were proposed, but the listings were finalized including this criterion.

⁴ See <https://www.americanprogress.org/issues/healthcare/reports/2019/10/18/475908/truth-wait-times-universal-coverage-systems/>

⁵ Among awarded SSDI beneficiaries, 12.7% were uninsured and 31.6% of those insured had public coverage, see <https://www.ssa.gov/policy/docs/ssb/v70n4/v70n4p25.html>. The uninsured percentage among claimants is likely higher because a portion of awarded beneficiaries were able to access Medicaid once concurrently awarded SSI.

evaluation process rather than Steps 4 and 5, which often require Administrative Law Judge hearings and testimony by vocational witnesses.

If SSA chooses not to make this flexibility permanent, we recommend that the TFR cease to be effective 12, rather than 6, months after the effective date of a determination by the Secretary of Health and Human Services under section 319 of the Public Health Service Act, 42 U.S.C. 247d, that the COVID-19 national public health emergency no longer exists. Claimants and medical providers will act gradually, not immediately, once the emergency ends, and there is likely to be a backlog of deferred care that will take more than six months to resolve.

Thank you for your consideration of these comments.

Sincerely,

A handwritten signature in black ink that reads "Barbara Silverstone". The signature is written in a cursive style with a large, stylized initial "B".

Barbara Silverstone
Executive Director