4191-02U

SOCIAL SECURITY ADMINISTRATION

20 CFR Parts 404 and 416

[Docket No. SSA-2012-0035]

RIN 0960-AH51

Revisions to Rules Regarding the Evaluation of Medical Evidence

AGENCY: Social Security Administration.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: We are proposing several revisions to our medical evidence rules. The proposals include redefining several key terms related to evidence, revising our list of acceptable medical sources (AMS), revising how we consider and articulate our consideration of medical opinions and prior administrative medical findings, revising who can be a medical consultant (MC) and psychological consultant (PC), revising our rules about treating sources, and reorganizing our evidence regulations for ease of use. These proposed revisions would conform our rules with the requirements of the Bipartisan Budget Act of 2015 (BBA), reflect changes in the national healthcare workforce and in the manner that individuals receive primary medical care, simplify and reorganize our rules to make them easier to understand and apply, allow us to continue to make accurate and consistent decisions, and emphasize the need for objective medical evidence in disability and blindness claims.

DATES: To ensure that we consider your comments, we must receive them by no later than [INSERT DATE 60 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL

REGISTER].

ADDRESSES: You may submit comments by any one of three methods – Internet, fax, or mail. Do not submit the same comments multiple times or by more than one method. Regardless of which method you choose, please state that your comments refer to Docket No. SSA-2012-0035 so that we may associate your comments with the correct regulation.

CAUTION: You should be careful to include in your comments only information that you wish to make publicly available. We strongly urge you not to include in your comments any personal information, such as Social Security numbers or medical information.

1. Internet: We strongly recommend that you submit your comments via the Internet. Please visit the Federal eRulemaking portal at http://www.regulations.gov. Use the "Search" function to find docket number SSA–2012–0035. The system will issue a tracking number to confirm your submission. You will not be able to view your comment immediately because we must post each comment manually. It may take up to a week for your comment to be viewable.

2. Fax: Fax comments to (410) 966-2830.

3. Mail: Mail your comments to the Office of Regulations and Reports Clearance, Social Security Administration, 3100 West High Rise Building, 6401 Security Boulevard, Baltimore, Maryland 21235–6401.

Comments and background documents are available for public viewing on the Federal eRulemaking portal at www.regulations.gov or in person, during regular business hours, by arranging with the contact person identified below.

FOR FURTHER INFORMATION CONTACT: Dan O'Brien, Office of Disability Policy, Social Security Administration, 6401 Security Boulevard, Baltimore, Maryland 21235-6401, (410) 597-1632. For information on eligibility or filing for benefits, call our national toll-free number, 1-800-772-1213, or TTY 1-800-325-0778, or visit our Internet site, Social Security Online, at www.socialsecurity.gov.

SUPPLEMENTARY INFORMATION:

PREAMBLE TABLE OF CONTENTS

I. Background

The Social Security Act (Act) mandates that we find an individual disabled only if he or she furnishes the medical and other evidence that we require.[1] Much of the terminology and organization of our current evidence rules remain the same as when we adopted them in 1991 (the 1991 final rules).[2] In the 1991 final rules, we defined evidence, listed categories of evidence, explained the factors we use to weigh medical opinions, and explained that we give controlling weight to medical opinions from treating sources about the nature and severity of claimants' impairments if they are well-supported by medically acceptable clinical and laboratory diagnostic techniques and are not inconsistent with other substantial evidence in the record. This latter rule is commonly known as our "treating physician rule."

We have modified these rules a few times since 1991. We expanded the list of AMSs who can be medical consultants, who can provide medical opinions, and who can provide us with objective medical evidence to establish the existence of an impairment(s) at step 2 of the sequential evaluation process.[3] We also issued rules that clarified how administrative law judges (ALJ) and the Appeals Council (AC) must consider opinion evidence from State agency medical and psychological consultants, other program physicians and psychologists, and medical experts whom we consult.[4] In addition, we have issued rules modifying the requirement that we recontact a person's medical

[1] 42 U.S.C. 423(d)(5)(A) and 42 U.S.C. 1382c(a)(3)(H)(i).
[2] Standards for Consultative Examinations and Existing Medical Evidence, 56 FR 36932 (Aug. 1, 1991).
[3] See, e.g., Federal Old-Age, Survivors and Disability Insurance and Supplemental Security Income for the Aged, Blind, and Disabled; Medical and Other Evidence of Your Impairment(s) and Definition of Medical Consultant, 65 FR 34950 (June 1, 2000). See also, Optometrists as "Acceptable Medical Sources" To Establish a Medically Determinable Impairment, 72 FR 9239 (March 1, 2007).
[4] Federal Old-Age, Survivors and Disability Insurance and Supplemental Security Income for the Aged, Blind, and Disabled; Evaluating Opinion Evidence, 65 FR 11866 (March 7, 2000).

source(s) when we need to resolve an inconsistency or insufficiency in the evidence he or she provided.[5] We also clarified a person's duty to submit medical and other evidence that relates to his or her disability claim.[6]

As part of our reevaluation of our regulations that deal with weighing medical opinions, we asked the Administrative Conference of the United States (ACUS)[7] to provide us with recommendations on how to improve our medical opinion evidence in the disability and blindness claims evaluation process. ACUS issued its Final Report (ACUS Final Report) in April 2013.[8]

In light of the ACUS Final report and our adjudicative experience, we are proposing a number of revisions to our medical source and opinion evidence regulations to make them easier to understand and use. We expect that these changes will help us further ensure our high level of accuracy in future determinations and decisions. We discuss each of these proposed revisions below.

We also propose to revise related rules about who can be MCs and PCs in conformity with requirements in the BBA.

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[5] How We Collect and Consider Evidence of Disability, 77 FR 10651 (February 23, 2012).
[6] See Id., and Submission of Evidence in Disability Claims, 80 FR 14828 (March 20, 2015).
[7] ACUS is "an independent federal agency dedicated to improving the administrative process through consensus-driven applied research, providing nonpartisan expert advice and recommendations for improvement of federal agency procedures." About the Administrative Conference of the United States (ACUS), available at http://www.acus.gov/about-administrative-conference-united-states-acus.
[8] Administrative Conference of the United States, SSA Disability Benefits Programs: Assessing the Efficacy of the Treating Physician Rule (April 3, 2013), available at http://www.acus.gov/sites/default/files/documents/Treating_Physician_Rule_Final_Report_4-3-2013_0.pdf.

II. Redefining and categorizing terms related to evidence

We propose to redefine and categorize several terms to make our rules of evidence easier to understand and use. We also propose to identify certain types of evidence that are inherently neither valuable nor persuasive for our purposes and for which we will not articulate an analysis in determinations and decisions.

A. What is evidence

Our current rules state that evidence is anything that we obtain or is submitted to us that relates to a claim.[9] Our rules list several types of evidence as examples: (1) objective medical evidence, (2) other evidence from medical sources (including medical opinions), (3) statements you or others make, (4) information from other sources, (5) decisions by any other governmental or nongovernmental agency, and (6) certain findings and opinions made by our employees and program experts.[10]

Our regulations also state that medical source opinions on issues reserved to the Commissioner do not satisfy our definition of a medical opinion.[11] We issued Social

[9] 20 CFR 404.1512(b) and 416.912(b).
[10] 20 CFR 404.1512(b)(1)(i)-(viii) and 416.912(b)(1)(i)-(viii).
[11] The current definition of issues reserved to the Commissioner is found in 404.1527(d)(2)-(d)(3) and 416.927(d)(2)-(d)(3).

Security Ruling (SSR) 96-5p to explain how we consider these opinions.[12] However, our adjudicative experience has shown that we can improve the current regulatory structure for categorizing and evaluating this evidence.

B. Overview of proposed revisions

We propose to reorganize and define categories of evidence to make them easier to apply in the disability adjudication process. The proposed categories of evidence are: (1) objective medical evidence, (2) medical opinions, (3) other medical evidence, (4) statements from nonmedical sources, and (5) prior administrative medical findings.[13] Each category would have a specific definition and purpose in our administrative process.

We would categorize evidence from medical sources other than our Federal and State agency MCs and PCs as objective medical evidence, medical opinions, or other medical evidence.[14] We would categorize evidence from our MCs and PCs as prior administrative medical findings.[15] We would categorize evidence from nonmedical sources, such as from the claimant, family, and employers, as statements from nonmedical sources.

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[12] SSR 96-5p: Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner (61 FR 34471) (July 2, 1996)).

[13] 20 CFR 404.1512(d) and 416.912(d).

[14] When the Appeals Council uses the expertise of the medical sources on its Medical Support Staff, we categorize and consider the evidence from those medical sources as we do for any medical source who is not an MC or PC. We would continue to follow this practice under the rules proposed in this NPRM.

[15] Our current rules clarify that when MCs and PCs are part of the adjudicative team that makes disability determinations, their findings are not evidence at the level at which they are made. See 20 CFR 404.1527(e)(1)(i) and 416.927(e)(1)(i). However, in subsequent levels of appeal, the MC and PC findings from the prior adjudicative levels become evidence. See 20 CFR 404.1527(e)(1)(ii) and 416.927(e)(1)(ii). This NPRM retains that distinction.

Because all evidence we would receive would fall within one of the categories of evidence, we would define all of the evidence categories. This means we would remove the current language that evidence is not limited to the listed examples because all evidence we receive would fit into a specified category of evidence.

We propose to list and define the categories of evidence in 20 CFR 404.1513(a)(1)-(5) and 416.913(a)(1)-(5). The following chart displays the proposed organization:

Category of Evidence	Source	Summary of definition
Objective medical evidence	Medical sources	Signs, laboratory findings, or both[16]
Medical opinions	Medical sources	Statements about functional limitations and abilities
Other medical evidence	Medical sources	All other evidence from medical sources that are not objective medical evidence or medical opinions
Statements from nonmedical sources	Nonmedical sources	All evidence from nonmedical sources
Prior administrative medical findings	MCs and PCs	Findings about medical issues made by MCs and PCs at a prior administrative level

We define and explain each category later in this preamble.

Additionally, we frequently receive documents from medical sources that contain different categories of evidence on a single page, such as treatment notes containing both

[16] Our current rules define signs and laboratory findings in 20 CFR 404.1528 and 416.928. We discuss the current definitions and our proposed definitions for these terms in the preamble section II.D. Objective medical evidence below.

a laboratory finding and a medical opinion interpreting that finding. We would continue to follow our current practice to treat each kind of evidence from a medical source according to its category of evidence, even if there is more than one category of evidence on a single page.

C. Medical sources

Medical evidence comes from medical sources. Our current rules define medical sources as AMSs or other healthcare providers who are not AMSs,[17] and identify who is an AMS in 20 CFR 404.1502 and 416.902.

We propose to revise our current definition of medical sources in 20 CFR 404.1502 and 416.902 to specify that a medical source must be an individual who is: (1) licensed as a healthcare worker by a State and working within the scope of practice permitted under State or Federal law, or (2) certified by a State as a speech-language pathologist or a school psychologist and acting within the scope of practice permitted under State or Federal law. We propose to specify these two requirements in order that we may categorize evidence from healthcare providers as evidence coming from medical sources practicing lawfully.

Because an entity, such as a hospital, may have possession of a medical source's evidence, we would clarify in proposed 20 CFR 404.1512(b)(1)(i) and 416.912(b)(1)(i)

[17] 20 CFR 404.1502 and 416.902.

that we will contact a claimant's medical sources and entities that maintain a claimant's medical evidence when we develop a complete medical history.

D. Objective medical evidence

We currently define objective medical evidence as signs and laboratory findings.[18] To clarify our current policy, we propose to redefine objective medical evidence as signs, laboratory findings, or both to make clear that signs alone or laboratory findings alone are objective medical evidence. We propose to include this definition in 20 CFR 404.1502(f) and 416.902(f).

As part of our effort to better organize our regulations, we propose to move the existing definitions for signs, symptoms, and laboratory findings from current 20 CFR 404.1528 and 416.928 to the definitions section of 20 CFR 404.1502 and 416.902. We also propose to remove 20 CFR 404.1528 and 416.928 and make conforming changes to other related sections.

For clarity, we also propose to make minor editorial revisions to the definition of laboratory findings in proposed 20 CFR 404.1502(c) and 416.902(g) that are consistent with our current policy.

E. Medical opinions

[18] 20 CFR 404.1512(b)(1)(i) and 416.912(b)(1)(i) as defined in 20 CFR 404.1528(b) and (c) and 416.928(b) and (c).

Our program experience suggests that the reorganization and clarification of our current definitions and rules about medical opinions would make them easier to understand and use. For example, the category of "medical opinions" is called “other evidence from medical sources” in 20 CFR 404.1512(b)(1)(ii) and 416.912(b)(1)(ii), but referred to as “statements from physicians, psychologists, or other [AMSs] that reflect judgments about the nature and severity of an individual’s impairment(s), including symptoms, diagnosis and prognosis, what the individual can still do despite impairment(s), and physical or mental restrictions” in 20 CFR 404.1527(a)(2) and 416.927(a)(2). Our current rules state that we weigh medical opinions using several factors as part of our consideration of this evidence.[19]

We discuss statements about what an individual can still do despite his or her impairment(s).[20] We state that such a statement should describe the kinds of physical and mental capabilities we list in those sections. Similarly, although we do not directly define the phrase "your physical or mental restrictions" in 20 CFR 404.1527(a)(2) and 416.927(a)(2), our current rules in 20 CFR 404.1545(b)-(d) and 416.945(b)-(d) state which abilities we look for that may be limited by physical or mental restrictions.

Our adjudicative experience has also shown that a narrower definition of medical opinions would improve our adjudicative process. Diagnoses and prognoses do not describe how an individual functions. Also, while we always consider a claimant’s own

[19] See 20 CFR 404.1527 and 416.927.
[20] 20 CFR 404.1513(c) and 416.913(c).

statements about his or her symptoms, how we consider this kind of evidence is different from how we consider evidence from medical sources.[21] A more appropriate focus of medical opinions would be perspectives from medical sources about claimants' functional abilities and limitations.

To help make our evidence rules easier to use and apply, we propose to redefine medical opinions to combine relevant, current text about functional abilities and limitations from different regulatory sections. We propose to specify that all medical sources other than MCs and PCs, not just AMSs, can create evidence that we will categorize as medical opinions. We also propose to remove symptoms, diagnosis, and prognosis from the current definition of medical opinions and add them to the definition of "other medical evidence" because these concepts do not describe a claimant's functional abilities and limitations. We propose to add a definition for medical opinion in 20 CFR 404.1513(a)(2) and 416.913(a)(2).

For adults filing for disability or blindness under titles II or XVI of the Act, a medical opinion would be a statement from a medical source about what an individual can still do and whether the individual has one or more impairment-related limitations or restrictions in specific abilities. For adult claims, we would specify which limitations and restrictions in current 20 CFR 404.1545 and 416.945 we would consider. For disability claims for children filing under title XVI of the Act, [22] we propose to refer to a child's

[21] See 404.1529 and 416.929.
[22] 20 CFR 416.906 states: "If you are under age 18, we will consider you disabled if you have a medically determinable physical or mental impairment or combination of impairments that causes marked and severe

abilities to function in the six domains of functioning found in current 20 CFR 416.926a(g)-(l).

We discuss our proposals about considering and articulating our consideration of medical opinions below in Section VI, Consideration and articulation of medical opinions and prior administrative medical findings.

F. Other medical evidence

Our current rules of evidence include a category of evidence referred to as "other evidence from medical sources," which includes medical history, opinions, and statements about treatment a claimant has received.[23] Our current rules also describe medical reports and imply that only AMSs can create medical reports.[24] Our rules describe medical reports by what they should include: (1) medical history, (2) clinical findings (such as the results of physical or mental status examinations); (3) laboratory findings (such as blood pressure, x-rays); (4) diagnosis (statement of disease or injury based on its signs and symptoms); (5) treatment prescribed with response and prognosis; and (6) a statement about a claimant's physical and mental abilities based on the AMS' findings.[25]

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functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months. Notwithstanding the preceding sentence, if you file a new application for benefits and you are engaging in substantial gainful activity, we will not consider you disabled. We discuss our rules for determining disability in children who file new applications in §§416.924 through 416.924b and §§416.925 through 416.926a."

[23] 20 CFR 404.1512(b)(1)(ii) and 416.912(b)(1)(ii).

[24] See 20 CFR 404.1512-404.1513(b), 404.1519g(a), and 416.912-416.913(b), and 404.919g(a).

[25] 20 CFR 404.1513(b)-(b)(6) and 416.913(b)-(b)(6).

To help make our evidence rules easier to use and apply, we propose to combine the categories "other evidence from medical sources" and "medical reports" into a single evidence category called “other medical evidence.” We also propose to clarify that all medical sources, not just AMSs, can produce other medical evidence. This category of evidence would include all medical evidence that is not objective medical evidence or a medical opinion, as well as examples of common kinds of evidence from our current rules. This would include items such as medical reports, diagnosis, and prognosis.

We propose to move judgments about the nature and severity of a claimant's symptoms, diagnosis, and prognosis from the current definition of medical opinion to the proposed definition of other medical evidence because these concepts do not describe a claimant's functional abilities and limitations. We also propose to exclude laboratory findings from the proposed definition of other medical evidence because this is already included as part of the proposed definition of objective medical evidence. We would make these revisions in proposed 20 CFR 404.1513(a)(2) and 416.913(a)(2).

We would continue to categorize and consider evidence from medical experts testifying at the hearings level and from medical sources in the Medical Support Staff at the Appeals Council in the same ways we consider evidence from all other medical sources who are not MCs or PCs.

G. Statements from nonmedical sources

Our current rules state that nonmedical sources can provide two types of evidence: (1) statements you or others make and (2) information from other sources.

First, we define the term "statements you or others make" as statements a claimant or others make about a claimant's impairment(s), restrictions, daily activities, efforts to work, or any other statement a claimant makes to medical sources during the course of examination or treatment, or to us during interviews, on applications, in letters, or in testimony during our administrative proceedings.[26]

Second, we define "information from other sources" by referencing 20 CFR 404.1513(d) and 416.913(d) for the definition of other sources.[27] In those sections, we define the term "other sources," for instance, as medical sources who are not listed as AMS, educational personnel, social welfare agency personnel, family members, friends, neighbors, and clergy.[28] There is no difference in how we consider a statement a claimant or other nonmedical source makes and information from other sources; both sources can produce evidence to show the severity of an impairment and how it affects an individual's ability to work.

To help make our evidence rules easier to use and apply, we propose to combine "statements you or others make" and "information from other sources" into one category

[26] 20 CFR 404.1512(b)(1)(iii) and 416.912(b)(1)(iii).
[27] 20 CFR 404.1512(b)(1)(iv) and 416.912(b)(1)(iv).
[28] 20 CFR 404.1513(d)(1)-(4) and 416.1513(d)(1)-(4).

of evidence to be called "statements from nonmedical sources." We would not include medical sources in this category of evidence. We would define this category of evidence as statements nonmedical sources make about an individual's impairment(s), restrictions, daily activities, efforts to work, or any other relevant statements an individual makes to medical sources during the course of examination or treatment, or to us during interviews, on applications, in letters, and in testimony in our administrative proceedings.

We also propose to distinguish between medical sources and nonmedical sources. A medical source would be someone currently classified as an AMS or another source listed in current 20 CFR 404.1513(d)(1) and 416.913(d)(1) who is licensed or certified as a healthcare worker by a State and working within the scope of their healthcare license or certification. Consistent with this realignment of our rules, we propose to define nonmedical sources in 20 CFR 404.1502 and 416.902 as a source of evidence who is not a medical source and specify that this includes the claimant, educational personnel, social welfare agency personnel, family members, caregivers, friends, neighbors, and clergy. We would continue to consider statements from nonmedical sources to be important evidence that we would consider under 20 CFR 404.1520b and 416.920b.

H. Prior administrative medical findings

State agencies make disability determinations at the initial and reconsideration levels of our administrative review process.[29] In most States, a disability examiner makes a disability determination together with a State agency MC or PC, as appropriate.[30] In States where we have been conducting our single decision maker pilot, our rules also allow Federal components to employ MCs and PCs to function just as they would for a State.[31]

The MCs and PCs create evidence that we currently categorize as both medical opinions and administrative findings of fact.[32] These administrative findings of fact are about medical issues, including, but not limited to, the existence and severity of impairment(s), the existence and severity of symptoms, whether an impairment(s) meets or medically equals the requirements for an impairment in our Listing of Impairments,[33] and an individual's residual functional capacity (RFC). Although MCs and PCs base these administrative findings of fact on evidence in the case, the administrative findings are not, in themselves, evidence at the level of the administrative review process at which we make the findings.[34] They become medical evidence at subsequent levels in the administrative review process that adjudicators must consider and weigh as opinion

[29] See 20 CFR 404.1615 and 416.1015.
[30] See 20 CFR 404.906(b)(2), 404.1615(c)(1), 416.1015(c)(1), and 416.1406(b)(2). In States where we are using a single decision maker (SDM) under the rules in 20 CFR 404.906 and 416.1406, when the State agency disability examiner makes the disability determination alone, the disability examiner may also consult with an MC or PC to help make a disability determination, when appropriate. However, section 832 of the Bipartisan Budget Act of 2015, Pub. L. 114-74, 129 Stat. 584, 613 affects the use of an SDM. This NPRM does not propose to change the rules that recognize SDM authority. We intend to publish a separate NPRM that discusses in more detail how we propose to end SDM authority.
[31] See 20 CFR 404.1661 and 416.1061.
[32] 20 CFR 404.1527(e) and 416.927(e).
[33] 20 CFR Part 404, Subpart P, Appendix 1.
[34] 20 CFR 404.1527(e)(1)(i) and 416.927(e)(1)(i).

evidence because MCs and PCs are highly qualified and are also experts in Social Security disability evaluation.[35]

To explain how we interpret these rules, we issued SSR 96-6p: Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence.[36] SSR 96-6p explains that when ALJs or the AC issue decisions, they must weigh these opinions and administrative findings of fact using the same factors used to weigh other medical opinions. It also explains that in appropriate circumstances an MC or PC opinion might be entitled to greater weight than an opinion from a claimant's treating source or an examining source.

In order to simplify our rules, we propose to combine the two types of evidence our current rules state MCs and PCs make—administrative findings of fact and medical opinions—into a single category of evidence called "prior administrative medical findings." We propose to define this evidence as findings about medical issues, other than the ultimate determination about whether you are disabled, made by our Federal and State agency medical and psychological consultants at a prior level of review based on their review of the evidence in your case record.

[35] 20 CFR 404.1527(e)(2)(i) and 416.927(e)(2)(i).
[36] 61 FR 34466 (July 2, 1996).

We propose to identify as prior administrative medical findings the following medical issues:

- the existence and severity of impairment(s);
- the existence and severity of symptoms;
- statements about whether an impairment(s) meets or medically equals the requirements for any impairment in the Listing of Impairments in 20 CFR Part 404, Subpart P, Appendix 1;
- in child claims under title XVI, whether an impairment(s) is functionally equivalent in severity to an impairment(s) in the Listing of Impairments in 20 CFR Part 404, Subpart P, Appendix 1;
- in adult claims, a claimant's residual functional capacity;
- whether an impairment(s) meets the duration requirement; and
- how the policies about failure to follow prescribed treatment and drug addiction and alcoholism relate to a claim.

These medical issues are similar to those currently listed in 20 CFR 404.1527(e)(1)(i) and 416.927(e)(1)(i). We would consider and articulate our consideration of prior administrative medical findings using the same factors we use to consider medical opinions from medical sources. However, due to our proposed revisions to the definition of the evidence category of medical opinion, we would remove from several regulation sections references to MCs and PCs making medical opinions.

Consistent with these proposals and our proposals below in Section VI, Consideration and articulation of medical opinions and prior administrative medical findings, we would also delete the definition of nonexamining source because it would be unnecessary as a result of other proposed revisions in this NPRM. We would also remove any reference to specialists during the initial and reconsideration levels because we would not use medical sources other than MCs and PCs. We propose to include these revisions in 20 CFR 404.1502, 404.1513(a)(6), 404.1513a, 416.902, 416.913(a)(6), and 416.913a.

I. Decisions by other governmental agencies and nongovernmental entities

Several other governmental agencies and nongovernmental entities make decisions using their own rules about disability, blindness, and employability. These organizations include the Department of Veterans Affairs (VA), the Department of Defense (DOD), the Office of Personnel Management (OPM), the Department of Labor (DOL), State workers compensation programs, and private long-term disability insurance programs. As part of our claim development, we sometimes receive decisions or information about decisions made by other governmental agencies and nongovernmental entities, as well as the evidence relied on to make these decisions. Our current rules include a category of evidence called "decisions by any governmental or nongovernmental agency about whether you are blind or disabled."[37] Our current rules state that these decisions are not binding on us because we must make a disability or

[37] 20 CFR 404.1512(b)(1)(v) and 416.912(b)(1)(v).

blindness decision based on the Act and our regulations.[38] We propose to clarify how we would consider disability and blindness decisions made by other agencies.

We address this aspect of our policy in SSR 06-03p,[39] in which we distinguish between issues reserved to the Commissioner—such as whether a claimant is disabled—and evidence that may have a bearing on our determination or decision of disability, including decisions by other governmental and nongovernmental agencies. In the ruling, we stated that we cannot ignore and must consider evidence of a disability decision by another governmental or nongovernmental agency. However, our program experience since we issued SSR 06-03p suggests we need to revise these policies.

There are four reasons why we should not need to consider or articulate in our written determinations or decisions our consideration of decisions from other governmental and nongovernmental agencies. First, the purpose of the Act and the specific eligibility requirements for disability and blindness benefits under titles II and XVI of the Act differ significantly from the purpose and eligibility requirements of other programs. These differences include eligibility criteria, duration, insured status, individualized versus categorical medical and functional assessments, onset rules, how subjective complaints are considered, employability findings, consideration of past work,

[38] 20 CFR 404.1504 and 416.904.
[39] SSR 06-03p: Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies, 71 FR 45593 (August 9, 2006).

and consideration of other work.[40] Therefore, other governmental agencies' or nongovernmental entities' decisions give us little indication whether a claimant is more or less likely to be found disabled or blind under the Act. Those decisions are not, by themselves, useful to us when we decide whether a claimant is disabled or blind under the Act and are therefore neither valuable nor persuasive evidence for determining disability or blindness under our rules.

For example, VA and SSA disability differ significantly in purpose as well as in eligibility criteria. In determining disability, the VA assigns a percentage disability rating based on a consideration of the effects of a disease or injury on a hypothetical, average person's ability to earn income without consideration of a specific veteran's age, education, or work experience.[41] In contrast, under our rules, unless a claimant's impairment(s) meets or medically equals a listing, we perform an individualized assessment that focuses on that particular claimant's ability to perform work in the national economy.

As part of this individualized assessment, the Act requires us to consider several criteria, such as whether a claimant has worked (substantial gainful activity), whether the claimant's impairment(s) is expected to last at least 12 months or result in death (the duration requirement), how the claimant's impairment(s) limit his or her physical and

[40] These differences among the various programs are well-documented. For example, the Government Accountability Office (GAO) produced a report that highlighted the differences among SSA, VA, and DOD disability programs. GAO, Social Security Disability: Additional Outreach and Collaboration on Sharing Medical Records Would Improve Wounded Warriors' Access to Benefits, GAO-09-762 (September 2009), available at http://www.gao.gov/assets/300/296693.pdf.
[41] 38 CFR 4.1.

mental ability to do work activities (severity and assessment of RFC), whether the claimant can perform in his or her past relevant work given his or her RFC, and whether the claimant's RFC, age, education, and work experience (the vocational factors) allow the claimant to perform other work that exists in significant numbers in the national economy. Thus, because of our different requirements, the mere fact that the VA process resulted in a particular disability rating is not predictive or useful evidence of whether the claimant will be found disabled under our rules, even upon consideration of the same impairment(s).

Similarly, the DOD and OPM follow rules that are substantially different from our rules when they make determinations on disability retirement. State agencies and the DOL make determinations under State and Federal workers' compensation programs, which vary from State to State and may involve determinations of partial disability, a concept that does not exist in our programs. These compensation programs may consider the individual's ability to do past work, but make no consideration of the individual's ability to do other work, as we are required to consider under our rules. Some States also make determinations about whether individuals are entitled to receive Medicaid and related benefits; however, those States may set individual eligibility criteria within the Federal minimum standards and may find individuals eligible to receive Medicaid for reasons other than disability. Furthermore, States may anticipate how we may interpret and apply our own rules regarding disability, but are not bound to follow our case development requirements and other regulations. Thus, in each instance, there are significant differences between our rules and the eligibility criteria and rules that other

agencies or entities follow. Therefore, a finding of "disability" or a decision to award benefits made by any other agency or entity is not predictive of whether a claimant would be found disabled under our rules.

Second, a record may indicate that another agency or entity decided to award benefits, but not include the decision itself. Alternatively, the decision might be in the record, but may not include any explanation about the factual findings or reasons for the decision. In those instances, there is nothing substantive about the decision for our adjudicators to consider.

Third, our adjudicators follow regulations and other guidance specific to our program; they generally do not have a detailed understanding of the rules other agencies or entities apply when making their decisions. Consequently, our adjudicators lack the expertise to compare and contrast the differences between the Act and our rules, and the rules applied by another agency or entity. Accordingly, when our adjudicators follow our instructions in SSR 06-03p that require them to consider decisions in the record from another agency or entity in the record, they often simply state that they considered the other agency's or entity's decision, but that it was not binding because it was made using the other agency's or entity's rules and not ours. Our current requirement that adjudicators consider other agency's or entity's decisions therefore imposes an unnecessary articulation requirement on our adjudicators.

Fourth, over time Federal courts have interpreted and applied our rules and SSR 06-03p differently in different jurisdictions. For example, in some circuits, the United States Courts of Appeals have stated that we should give disability decisions from the VA great or substantial weight absent some reasoned, fact-specific explanation for discounting the VA disability decisions.[42] We administer a national disability program, and our goal is to apply rules uniformly.

We propose to revise our rules in 20 CFR 404.1504 and 416.904 to state that we will not provide any analysis in our determinations and decisions about how we consider decisions made by other governmental agencies or nongovernmental entities that an individual is disabled, blind, or unemployable in any claim for disability or blindness under titles II and XVI of the Act, and that we are not bound by those decisions. Although we would categorize decisions made by other governmental agencies or nongovernmental entities within the other medical evidence category if made by a

[42] For example, the Ninth Circuit held that our ALJs must "ordinarily give great weight to a VA determination of disability" although "the ALJ may give less weight to a VA disability rating if he gives persuasive, specific, valid reasons for doing so that are supported by the record." McCartey v. Massanari 298 F.3d 1072, 1076 (9th Cir. 2002). This principle has been followed in a number of more recent cases. See, e.g., Valentine v. Comm'r Soc. Sec. Admin., 574 F.3d 685, 694–95 (9th Cir. 2009) (ALJ's explanation for giving little weight to a VA disability determination that rested on the general grounds that the VA and SSA inquiries are different ran afoul of McCartey, although the ALJ's reliance on evidence not before the VA was a persuasive, specific, and valid reason); Berry v. Astrue, 622 F.3d 1228, 1236 (9th Cir. 2010) (rejecting two reasons the ALJ gave for discounting a VA determination, accepting a third "in part," and remanding for reconsideration of the VA disability determination); McLeod v. Astrue, 640 F.3d 881, 885–86 (9th Cir. 2011) (claimant denied a full and fair hearing because the record suggested he had a VA disability rating, which was not in the record); Hiler v. Astrue, 687 F.3d 1208, 1211–12 (9th Cir. 2012) (ALJ misunderstood and did not properly evaluate the three VA decisions in the record). The Fourth Circuit has found McCartey persuasive and held that "SSA must give substantial weight to a VA disability rating" although "an ALJ may give less weight to a VA disability rating when the record before the ALJ clearly demonstrates that such a deviation is appropriate." Bird v. Astrue, 699 F.3d 337, 343 (4th Cir. 2012). Subsequently, at least one district court within the Fourth Circuit has interpreted Bird as announcing a new standard for evaluating VA decisions. See, e.g.,, Persaud v. Colvin, No. 2:12-cv-661, 2014 WL 198922, *8–11 (E.D. Va. Jan. 14, 2014); Jacobs v. Colvin, No. 2:12-cv-508, 2013 WL 5741538, *5–7 (E.D. Va. Oct. 22, 2013).

medical source or a statement if made by a nonmedical source, we propose to state in 20 CFR 404.1520b and 416.920b that these decisions are inherently neither valuable nor persuasive to our disability and blindness determinations.

Importantly, however, we would continue to consider relevant medical and other evidence that supports or underlies other governmental agencies' or nongovernmental entities' decisions that we receive based on the applicable evidence categories proposed above. For example, we would continue to consider a compensation and pension examination from a VA physician that underlies a VA disability rating, even though our adjudicators would not be required to give any particular weight to or analyze the specific VA disability rating. Similarly, we would continue to consider a medical opinion from a medical source submitted in support of a claimant's workers' compensation claim or Medicaid application, even though our adjudicators would not be required to give any weight to or discuss the decision to award workers' compensation or Medicaid benefits.

We could also still use information from other governmental agencies or nongovernmental entities we receive to process claims. For example, we would retain authority to expedite processing of claims for Wounded Warriors and for veterans with a 100% VA disability compensation rating, as we do now.[43]

[43] See Information for Wounded Warriors and Veterans Who Have a Compensation Rating of 100% Permanent & Total (P&T), available at https://www.ssa.gov/people/veterans.

For clarity, we also propose to change our current regulatory term "decisions by other organizations and agencies" to "decisions by other government agencies and nongovernment entities."

J. Disability examiner findings

Currently, in most States, disability examiners consult with MCs and PCs to make disability and blindness determinations at the initial and reconsideration levels of the administrative appeals process.[44] The disability examiner's findings about medical issues, vocational issues, and whether an individual is disabled becomes our determination. Under our current rules, we do not weigh disability examiner findings at subsequent levels of the administrative appeals process because adjudicators at each level make new findings for their determination or decision. This is in contrast to how we treat administrative findings about medical issues by MCs and PCs, which are evidence we weigh at subsequent levels of review. While this distinction is implied in our current regulation,[45] we propose to state in 20 CFR 404.1520b(c)(2) and 416.920b(c)(2) that we will not provide any analysis about how we considered disability examiner findings from a prior level of adjudication.

K. Statements on issues reserved to the Commissioner

[44] Some States use SDMs in certain situations to make a disability determination without consulting an MC or PC. See 20 CFR 404.906(b)(2), 404.1615(c), 416.1015(c), and 416.1406(b)(2).
[45] See 20 CFR 404.1512(b)(6)-(8) and 416.912(b)(6)-(8).

Statements on issues reserved to the Commissioner consist of opinions or statements about how we should interpret and apply our policies to a claim instead of simply stating a claimant's abilities and limitations. Although our current list of evidence types in 20 CFR 404.1512 and 416.912 does not include issues reserved to the Commissioner, our rules do discuss medical source opinions on issues reserved to the Commissioner in 20 CFR 404.1527(d) and 416.927(d). Our rules state that opinions on issues reserved to the Commissioner are not medical opinions, because they are administrative findings that are dispositive of a case, i.e., that direct the determination or decision of disability. We give several examples of issues reserved to the Commissioner. These include statements by medical sources that a claimant is disabled or unable to work, whether a claimant's impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments, a claimant's RFC, and how we should apply the vocational factors.

We issued SSR 96-5p to explain how we consider these types of opinions.[46] The SSR states: (1) the difference between issues reserved to the Commissioner and medical opinions; (2) that treating source opinions on issues reserved to the Commissioner are never entitled to controlling weight or special significance; (3) that opinions from any medical source about issues reserved to the Commissioner must never be ignored, and that the notice of the determination or decision must explain the consideration given to

[46] SSR 96-5p: Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner (61 FR 34471(July 2, 1996)).

the treating source's opinion(s); and (4) the difference between the opinion called a medical source statement and the administrative finding called an RFC assessment.[47]

Since we published SSR 96-5p, we have frequently received requests to provide further guidance about how to identify and evaluate opinions about issues reserved to the Commissioner. One area we have been asked to clarify is how to consider and weigh the opinions because we do not give them any special significance. We also have received requests to provide additional examples of issues that are reserved to the Commissioner.

Consistent with our goals to better define and organize our evidence regulations to produce more accurate and consistent determinations and decisions, we propose to define a statement on an issue reserved to the Commissioner as a statement that would direct the determination or decision of disability. Because we are responsible for making the determination or decision about whether a person meets the statutory definition of disability, a statement on an issue reserved to the Commissioner is inherently neither valuable nor persuasive to us. Although a statement on an issue reserved to the Commissioner would be categorized within other medical evidence if made by a medical source or a statement if made by a nonmedical source, we would not provide any analysis about how we considered such statements at all in our determinations and decisions.

[47] The SSR also included a discussion about requirements for recontacting treating sources. Since the publication of the SSR, we also published final rules that revised how we consider medical source statements from State disability examiners (65 FR 11866 (March 7, 2000)).

An example of a medical opinion that we could consider valuable or persuasive and that we may provide analysis about in a determination or decision is a medical source's statement that a claimant could lift 10 pounds for up to one-third of an 8-hour day and less than 10 pounds for up to two-thirds of an 8-hour day, stand and walk for about 2 hours of an 8-hour day, and sit for up to 6 hours of an 8-hour day. An example of a statement on an issue reserved to the Commissioner that we would not provide any analysis about in a determination or decision because it is inherently neither valuable nor persuasive is that the claimant has an RFC for sedentary work. The second statement is an issue reserved to the Commissioner because it includes assumptions about what particular medical limitations and restrictions mean in terms of our policy.

Another example of a statement on an issue reserved to the Commissioner that we would not provide any analysis about in a determination or decision is that the claimant "is disabled." This statement includes assumptions about how we should apply our policy in a particular claim.

To help adjudicators, representatives, and courts identify statements on issues reserved to the Commissioner, we propose to include the following in 20 CFR 404.1520b(c)(3) and 416.920b(c)(3):

- statements that an individual is or is not disabled, blind, able to work, or able to perform regular or continuing work;
- statements about whether or not an individual's impairment(s) meets the duration requirement for disability;

- statements about whether or not an individual's impairment(s) meets or equals any listing in the Listing of Impairments;
- in title XVI child claims, statements about whether or not an individual's impairment(s) functionally equals the Listings;
- in adult claims, statements about what an individual's RFC is using our programmatic terms about the functional exertional levels in Part 404, Subpart P, Appendix 2, Rule 200.00 instead of descriptions about his or her functional abilities and limitations;
- in adult claims, statements about whether or not an individual's RFC prevents him or her from doing past relevant work;
- in adult claims, statements that an individual does or does not meet the requirements of a medical-vocational rule in Part 404, Subpart P, Appendix 2; and
- statements about whether or not an individual's disability continues or ends when we conduct a continuing disability review (CDR).

We would also rescind SSR 96-5p consistent with these proposed revisions.

III. Establishing the existence of an impairment

A. Current rules

To be found disabled under titles II or XVI of the Act,[48] an individual must have a physical or mental impairment that results from anatomical, physiological, or psychological abnormalities that are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.[49] At step 2 of the sequential evaluation process, we determine both whether an individual has a medically determinable impairment(s) and, once the existence of the impairment(s) is established, whether it is severe.[50]

We interpret the Act as requiring us to obtain objective medical evidence — signs or laboratory findings — from an AMS to establish the existence of a medically determinable impairment.[51] Once we have objective medical evidence from an AMS showing that the claimant has a medically determinable impairment or combination of impairments at step 2, we then consider evidence from all sources, regardless of AMS status, to determine the severity of those impairments at step 2. If we do not have objective evidence from an AMS to establish the existence of an impairment, we try to get this evidence from a claimant's own AMS or by purchasing a consultative examination (CE) with an AMS.[52] Even if we already have evidence of signs or laboratory findings from a medical source who is not an AMS, under our current policy we cannot use this evidence to establish the existence of a medically determinable impairment.

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[48] The Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months." 42 U.S.C. 423(d) and 1382c(a)(3). We have a different definition for determining statutory blindness. See 42 U.S.C. 416(i)(1) and 1382c(a)(2).
[49] 42 U.S.C. 423(d)(3) and 1382c(a)(3)(D).
[50] See 20 CFR 404.1520(a)(4)(ii) and 416.920(a)(4)(ii).
[51] See, e.g., SSR 16–3p; Titles II and XVI: Evaluation of Symptoms in Disability Claims, 81 FR 14166 (March 16, 2016).
[52] See 20 CFR 404.1519a and 416.919a.

Our current policies also preclude the following types of evidence from establishing the existence of a medically determinable impairment at step 2 because they are not objective medical evidence: (1) a statement of symptoms, (2) a diagnosis, and (3) a medical opinion.[53] The Act requires medically acceptable clinical and laboratory diagnostic techniques as evidence.[54] A claimant's self-reported symptoms and a medical source's own subjective opinion do not meet this statutory requirement. We also cannot rely on a diagnosis to establish the existence of an impairment because sometimes medical sources diagnose individuals without using objective medical evidence. For example, a medical source may rely on a claimant's reported symptoms or another medical source's medical opinion, treat reported symptoms under a provisional diagnosis, or rule-out diagnosis without making this clear in the treatment note. In addition, we have found—especially with electronic medical records—diagnoses that are listed solely for billing and medical insurance reasons but that do not include supporting objective medical evidence.

B. Proposed revisions

In order to assist representatives and our adjudicators in interpreting our rules, we propose to revise our rules to state affirmatively our current policy that we will not use a diagnosis, medical opinion, or an individual's statement of symptoms to establish the existence of an impairment(s). We would clarify our rules to state that a physical or

[53] See 20 CFR 404.1508, 404.1528(a), 404.1529, 416.908, 416.928(a), and 416.929 and SSR 96-2p.
[54] 42 U.S.C. 423(d)(3) and 1382c(a)(3)(D).

mental impairment must be established by objective medical evidence from an AMS. We would continue to follow our current policy if we have objective medical evidence from an AMS that a claimant has a severe impairment(s) at step 2, we will consider all evidence to determine the severity of the impairment(s) and all other findings in the sequential evaluation process. We would also continue to follow our current policy in 20 CFR 404.1529 and 416.929 about how we evaluate symptoms, including pain, when we determine severity and RFC. We would make these revisions to 20 CFR 404.1521, 404.1522, 416.921, and 416.922.

IV. Acceptable medical sources (AMS)

A. Current AMS rules

As noted above, under our current policy, only objective medical evidence from AMSs can be used to establish an impairment(s) at step 2 of the sequential evaluation process. Also, as we discuss below in "Treating Sources," only AMSs can be treating sources. Our current rules recognize the following medical sources as AMSs:

- Licensed physicians (medical or osteopathic doctors).
- Licensed or certified psychologists. Included are school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, for purposes of establishing intellectual disability, learning disabilities, and borderline intellectual functioning only.

- Licensed optometrists, for purposes of establishing visual disorders only (except, in the U.S. Virgin Islands, licensed optometrists, for the measurement of visual acuity and visual fields only).
- Licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle.
- Qualified speech-language pathologists, for purposes of establishing speech or language impairments only. For this source, qualified means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of Clinical Competence from the American Speech-Language-Hearing Association.[55]

B. Why we are proposing to add new AMSs

We propose to revise our rules to reflect changes in the national healthcare workforce and the manner that many people now receive primary medical care. Much of the medical evidence we receive in disability claims comes from primary care providers. Under our current rules, we are not able to consider an increasing number of primary care providers to be AMSs. For example, more than 50 percent of the nation's more than

[55] 20 CFR 404.1513(a) and 416.913(a)

55,000 nurse practitioners specialize in primary care,[56] and the total number of nurse practitioners increased almost 28 percent from 2004 to 2011.[57] A nurse practitioner is one type of Advanced Practice Registered Nurses (APRN) we propose to add to our AMS list below. Nurse practitioners provide diagnostic and clinical treatment of acute and chronic illnesses. In the U.S., there is a simultaneous increasing shortage of primary care physicians.[58] In fact, the American Association of Medical Colleges predicts a shortage of 90,000 primary care physicians by 2020.[59] The Institute of Medicine recommended Federal agencies recognize the advanced level of care provided by APRNs.[60]

Similarly, an increasing percentage of healthcare services for hearing-related impairments come from audiologists instead of physicians.[61] The Bureau of Labor Statistics predicts employment of audiologists will increase 25 percent by 2018.[62] Audiologists assess, diagnose, and treat dysfunction in hearing, auditory and vestibular function, balance, and related disorders by obtaining a complete history and performing

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[56] Agency for Healthcare Research and Quality, Primary Care Workforce Facts and Stats No. 3, available at http://www.ahrq.gov/research/findings/factsheets/primary/pcwork3/index.html.
[57] American College of Nurse Practitioners, Numbers of Nurse Practitioners, available at http://www.acnpweb.org; The Henry J. Kaiser Family Foundation, Total Nurse Practitioners, 2011, available at http://www.statehealthfacts.org.; U.S. Bureau of Labor Statistics, available at http://www.bls.gov/ooh/Healthcare/Physician-assistants.htm.
[58] Kaiser Commission on Medicaid and the Uninsured, Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants, available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8167.pdf.
[59] American Association of Medical Colleges, More U.S. Medical Students Match to Primary Care for Second Consecutive Year, available at https://www.aamc.org/newsroom.
[60]Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine; Institute of Medicine: The Future of Nursing: Leading Change, Advancing Health (2011), available at http://www.nationalacademies.org/hmd/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health/Report-Brief-Scope-of-Practice.aspx.
[61] See, for example, Sieminski, Louis R. The audiologist's role in early intervention. Hearing Journal. Vol 63 (1): 35 (2010).
[62] U.S. Bureau of Labor Statistics, Occupational Outlook Handbook, available at http://www.bls.gov/ooh/healthcare/audiologists.htm.

tests that include otoscopic examination, pure-tone audiometry, tympanometry, otoacoustic emissions measurements, and speech audiometry.

Uneven geographic distribution of the healthcare workforce makes it difficult for individuals living in rural areas to access primary care providers who are AMSs. APRNs are more likely than licensed physicians to work in rural areas and to provide primary care treatment to those with limited access to physicians.[63]

Additionally, the National Law Center on Homelessness and Poverty (NLCHP) has expressed concern that the limited list of AMSs creates unnecessary delays in processing disability applications for low-income claimants who may receive primary healthcare only from non-AMS medical sources, such as APRNs.[64] NLCHP notes that health professionals other than physicians and psychiatrists staff most programs for homeless claimants. As stated above, we pay for expensive consultative examinations with AMSs to establish the existence of an impairment when we already have this objective medical evidence from medical sources who are not AMSs. Adding these additional qualified AMSs would also reduce the need to pay for consultative examinations.

C. Proposed new AMSs

[63] Agency for Healthcare Research and Quality, available at http://www.ahrq.gov/research/findings/factsheets/primary/pcwork3/index.html.

[64] National Law Center on Homelessness and Poverty, Improving Access: Expanding Acceptable Medical Sources for the Social Security Administration Disability Determination Process, (2012), pg. 1, available at http://www.manatt.com/uploadedFiles/Content/News_and_Events/Firm_News/5.14.12%20Improving%20Access,%20FINAL[1].pdf.

We propose to recognize both audiologists and APRNs with specific scope of practice requirements as AMSs in 20 CFR 404.1502(a) and 416.902(a). We propose to add to the AMS list licensed audiologists for purposes of establishing hearing loss and auditory processing disorders. We also propose to add to the AMS list APRNs and other licensed advanced practice nurses with other titles acting within their licensed scope of practice. For the reasons discussed below, we are satisfied that these medical sources have sufficiently consistent and rigorous national licensing requirements for education, training, certification, and scope of practice.

Audiologists provide a substantial amount of the healthcare for hearing-related impairments and States have dramatically increased licensing requirements for audiologists during the past decade. Audiologists obtain State licensure after completing a master's or doctoral level-degree in a nationally accredited educational program. Most States require audiologists to pass a national audiology exam, such as the National Examination in Audiology administered by the Educational Testing Service, and to complete a significant number of supervised clinical training hours. Many States recognize that the nearly uniform criteria for certification from the American Board of Audiology (ABA) or a Certificate of Clinical Competence in Audiology (CCC-A) from the American Speech-Language-Hearing Association (ASHA) meet or exceed the States' own audiology licensing requirements. To receive certification from the ABA, an audiologist must complete doctoral coursework, pass a national audiology examination, and complete 2,000 supervised hours of direct patient care. To receive a CCC-A, an

audiologist must obtain a doctoral degree, pass the National Examination in Audiology, and complete a minimum of 1,820 supervised hours of clinical practicum.

With a few minor State variations, there are four main kinds of APRNs: Certified Nurse Midwife, Nurse Practitioner, Certified Registered Nurse Anesthetist, and Clinical Nurse Specialist. Although the majority of States use the APRN title, a minority of States use other similar titles, such as Advanced Practice Nurse and Advanced Registered Nurse Practitioner. We propose to consider all of these medical source groups as AMSs if they are licensed by a State and acting within the scope of their practice. We would maintain a current list of State-specific AMS titles in our subregulatory instructions. We would not categorize evidence from an APRN to be AMS evidence if the APRN acted outside of his or her scope of practice, since under such circumstances, an APRN would be violating his or her State license.

State licensure requirements for APRNs are rigorous. To receive APRN licensure, all States require these medical sources to have a registered nurse license and an advanced nursing educational degree.[65] In addition, nearly all States require APRNs to obtain and maintain national certification by a standard advanced nursing credentialing agency,[66] and these credentials require extensive education and training requirements.[67]

[65] In a very few States, the advanced nursing educational degree requirement may be achieved indirectly from the requirement to obtain the national certification. See Indiana's Administrative Code 848 IAC 4-1-4 about Nurse Practitioners, available at http://www.in.gov/pla/files/ISBN.2011_EDITION.pdf. See also South Dakota law 20:48:05:01 about Certified Registered Nurse Anesthetists, available at http://legis.sd.gov/Rules/DisplayRule.aspx?Rule=20:48:05:01.

[66] In a very few States, the advanced nursing credentialing is optional. These are: 1) California for Nurse Practitioners, see Cal.C.Reg. 16.8.1482, available at http://www.rn.ca.gov/pdfs/regulations/bp2834-r.pdf; 2) Indiana for Nurse Practitioners and Clinical Nurse Specialists, see Indiana's Administrative Code 848

Despite minor variability in nomenclature and licensure requirements, a growing majority of States are adopting the Consensus Model for APRN Regulation from the American Association of Nurse Practitioners, which defines the standards for licensure, accreditation, certification, education, and practice.[68] Given the number of States and types of licenses, we consider the very few current differences in licensing requirements not to outweigh the sufficiently national and increasingly uniform State requirements, especially given the trend to full implementation of the Consensus Model for APRN Regulation.

While we believe that these medical sources reflect the modern primary healthcare delivery system and are among the most highly qualified medical sources, we are particularly interested in receiving public comment on which criteria we should use when we determine which medical sources should be an AMS.

In particular, we are interested in public comments about whether we should add physician assistants (PAs) to the AMS list. PAs are significant health care providers for certain underserved populations, including those in rural communities. We would like public comments on whether the licensing, education, and training requirements for PAs are sufficient and consistent across States for PAs to be considered AMSs in all

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IAC 4-1-4 and -5, available at http://www.in.gov/pla/files/ISBN.2011_EDITION.pdf; 3) New York, see Education Law Article 139 §6910 for Nurse Practitioners and Clinical Nurse Specialists , available at http://www.op.nysed.gov/prof/nurse/article139.htm, and Article 140 §79-5.2 for Midwives, available at http://www.op.nysed.gov/prof/midwife/part79-5.htm; and 4) Oregon for Clinical Nurse Specialists, see Oregon Rules 851-054-0040, available at http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_851/851_054.html.

[67] See, for example, the American Academy of Nurse Practitioners Certification Program, available at http://www.aanpcert.org/ptistore/control/certs/qualifications.

[68] Available at http://www.aacn.nche.edu/education-resources/APRNReport.pdf.

cases. We would also like public comments on whether there are additional criteria we should use to support the inclusion of PAs on the AMS list in particular circumstances, and how we should consider these issues in the context of a national disability program with uniform rules. We are also interested in whether or not there are other professionals, such as licensed clinical social workers, who we should include on the AMS list.

D. Other revisions to the current AMS list

We propose to make six additional revisions to our current AMS list. The first two proposed revisions would update our rules about optometrists to reflect current State law about scope of practice. Our current rules include licensed optometrists for establishing visual disorders only, except in the U.S. Virgin Islands where licensed optometrists are included for the measurement of visual acuity and visual fields only.[69] Subsequent to publication of the final rule in 2007 that added optometrists to the AMS and medical consultant list,[70] the U.S. Virgin Islands enacted legislation that authorized full scope of practice for optometrists.[71] Therefore, we propose to delete the exception for licensed optometrists in the U.S. Virgin Islands from our rules.

On the other hand, Puerto Rico now has a limited scope of practice for licensed optometrists. Although licensed optometrists in Puerto Rico can perform visual acuity examination and visual field measurement, they are unable to prescribe medication or

[69] 20 CFR 404.1513(a)(3) and 416.913(a)(3).
[70] 72 FR 9239 (March 1, 2007).
[71] Act 7376, available at http://www.legvi.org/vilegsearch/ShowPDF.aspx?num=7376&type=Act, see also 27 V.I.C. 161(a), available at http://www.lexisnexis.com/hottopics/vicode.

perform surgery.[72] Consequently, in proposed 20 CFR 404.1502(a)(3) and 416.902(a)(3), we propose to limit licensed optometrists in Puerto Rico to the measurement of visual acuity and visual fields as is consistent with their scope of practice.

Our third proposal is to revise our definition of psychologists as AMSs to include independently practicing, licensed or certified, psychologists. All of these psychologists have a minimum of a master's degree. Although this is our subregulatory interpretation of the current regulatory language,[73] we believe it would be clearer to place it in the regulatory language.

Fourth, we propose to enumerate school psychologists separately from psychologists to clarify that the current "independent practice level" requirement applies to licensed or certified psychologists only but not to school psychologists. This is not a change in our current policy.

Fifth, we propose to revise our rules to reflect that the title of the certificate that the ASHA issues to qualified speech-language pathologists is now a Certificate of Clinical Competence in Speech-Language Pathology. Our current rules in 20 CFR 404.1513(a)(5) and 416.913(a)(5) state that the certification is a Certificate of Clinical

[72] See 20 LPRA 544(b)(1), available at http://www.lexisnexis.com/hottopics/lawsofpuertorico/.
[73] See POMS DI 22505.004 Establishing the Credentials for Psychologists and School Psychologists Who Do Not Show Their Licensing or Certification Status, available at https://secure.ssa.gov/apps10/poms.nsf/lnx/0422505004.

Competence. We propose to make this revision in proposed 20 CFR 404.1502 and 416.902.

Sixth, we propose to revise how we use evidence from medical sources on the AMS list. For most AMS sources, our regulations state the medical source is an AMS for the purpose of establishing a particular kind of impairment(s). Because we use evidence from AMSs for additional purposes, such as determining whose medical opinions we articulate in a determination or decision, we propose to revise our regulations to allow the use of evidence "for impairment(s) of" in order to better describe what AMS status means in our rules. We propose to make this revision to 20 CFR 404.1502(a)(2)(ii)-(7) and 416.902(a)(2)(ii)-(7).

E. Related revisions to our listings

Because we propose to recognize audiologists as AMSs, we also propose to revise our rules to specify what evidence would establish a medically determinable impairment that causes hearing loss that could meet the requirement of a listing in the Listing of Impairments.[74] Under our Special Senses and Speech Listings, we currently require a complete otologic examination by a licensed physician (medical or osteopathic doctor) to establish a medically determinable impairment that causes hearing loss.[75] We propose to remove the word “complete” because we currently specify the information we need in listing 2.00B2b and 102.00B2b, and we expect medical providers to follow professional

[74] See 20 CFR 404.1525 and 416.925.
[75] 20 CFR Part 404, Subpart P, Appendix 1 sections 2.00B2b for adults and 102.00B2b.

standards for conducting examinations. We also propose to specify that audiologists, because they would be AMSs, could also perform the otologic examination. We propose to make these revisions in 20 CFR Part 404, Subpart P, Appendix 1 sections 2.00B for adults and 102.00B for children.

V. Revisions to our list of medical sources who can be MCs and PCs

BBA section 832 states that when there is evidence indicating the existence of a physical impairment in a claim, we may not make an initial disability determination until we have made every reasonable effort to ensure that a qualified physician has completed the medical portion of the case review and any applicable RFC assessment.[76] Similarly, BBA section 832 states that when there is evidence indicating the existence of a mental impairment in a claim, we may not make an initial disability determination until we have made every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable RFC assessment.[77] These requirements will apply to how State agency DDSs use MCs and PCs to complete the medical portion of the case review and any applicable RFC assessment(s) at both the initial and reconsideration levels.

To implement BBA section 832, we propose several revisions about who can be MCs and PCs who can complete the medical portion of the case review and any applicable RFC assessment(s).

[76] Pub, L, 114-74, § 832, Stat. 584, 613.
[77] Id.

First, we currently authorize licensed physicians (medical or osteopathic) to be MCs who can complete the medical portion of the case review and any applicable RFC assessment for all physical impairments.[78] We also authorize licensed optometrists, podiatrists, and speech-language pathologists to be MCs who can complete the medical portion of the case review and any applicable residual functional capacity assessment about physical impairments in their scope of practice.[79] To implement BBA section 832, we propose to authorize only licensed physicians to be MCs, who must complete the medical portion of the case review and any applicable RFC assessment for physical impairments in a claim.

Second, when we propose to deny a claim involving mental impairments, we are currently required to make every reasonable effort to ensure that a psychiatrist or psychologist completes the medical portion of the case review and any applicable RFC assessment. In practice psychiatrists and qualified psychologists also typically review claims we propose to allow.[80] Our current regulations define the steps we must take to make every reasonable effort, as prescribed in section 221(h) of the Act. Current 20 CFR 404.1617 and 416.1017 states that if we are unable to obtain the services of a qualified psychologist or psychiatrist after making every reasonable effort, then we authorize an MC who is a physician to complete the medical portion of the case review and any

[78] 20 CFR 404.1616(b) and 416.1016(b).
[79] 20 CFR 404.1616(b) and (c) and 416.1016(b) and (c).
[80] 20 CFR 404.1615(d), 404.1616(d), 416.1015(d), and 416.1016(d).

applicable residual functional capacity assessment for mental impairments in a claim.[81] To implement BBA section 832, we propose to make every reasonable effort to ensure that psychiatrists or psychologists complete the medical portion of a case review and any applicable RFC assessment for mental impairments whether we propose to allow or deny a claim.

Third, BBA section 832 requires us to make every reasonable effort to ensure that a qualified physician has completed the medical portion of the case review and any applicable residual functional capacity assessment about physical impairment(s) before we make an initial determination, just as we make every reasonable effort for claims involving mental impairments. To implement BBA section 832, we propose to also make every reasonable effort to have physicians complete the medical portion of the case review and any applicable RFC assessment about physical impairments in a claim.

Fourth, we propose to revise our rules about who can be a PC. BBA section 832 states both psychiatrists and psychologists can make the medical assessment for mental impairments. For clarity, we propose to specify that a psychiatrist, who is a licensed physician, could serve as either an MC or PC. Instead of separately enumerating what constitutes a "qualified" psychologist who can be a PC, we also propose to define a psychologist in the same way we propose in our rules on AMSs in 20 CFR 404.1502(a)(2) and 416.902(a)(2) .

[81] Id.

We propose to make these revisions to 20 CFR 404.1615 - 404.1617 and 416.1015 - 416.1017. Because BBA section 832 becomes effective for determinations made on and after November 2, 2016, we would begin applying these revisions to our MC and PC rules on that date.

VI. Consideration and articulation of medical opinions and prior administrative medical findings

A. Our current rules about considering medical opinions and administrative findings of fact

We consider all evidence in a claim, including medical opinions, when we determine disability.[82] Our current rules explain the process we use to weigh medical opinions and administrative findings of fact.[83] We consider the following factors when we weigh a medical opinion and an administrative finding of fact:

- Examining relationship. Generally, we give more weight to the opinion of a source who has examined a claimant than to the opinion of a source who has not examined a claimant.[84]
- Treatment relationship. Generally, we give more weight to opinions from a claimant's treating sources because these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of a claimant's

[82] 42 U.S.C. 423(d)(5)(B) and 1382c(H)(i). See also 20 CFR 404.1520(a)(3), 404.1527(b), 416.920(a)(3), and 416.927(b).
[83] See 20 CFR 404.1527(c) and 416.927(c).
[84] 20 CFR 404.1527(c)(1) and 416.927(c)(1).

medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. Within the treatment relationship factor, we also consider these sub-factors:

1. Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated a claimant and the more times a treating source has seen a claimant, the more weight we will give to the source's medical opinion. When a treating source has seen a claimant a number of times and long enough to have obtained a longitudinal picture of a claimant's impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.[85]
2. Nature and extent of the treatment relationship. Generally, the more knowledge a treating source has about a claimant's impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if an ophthalmologist notices that a claimant complained of neck pain during an eye examination, we will consider his or her opinion with respect to the neck pain, but we will give it less weight than that of another physician

[85] 20 CFR 404.1527(c)(2)-(c)(2)(i) and 416.927(c)(2)-(c)(2)(i).

who has treated the claimant for the neck pain. When the treating source has reasonable knowledge of the claimant's impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.[86]

- Supportability. The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because non-examining sources have no examining or treating relationship with a claimant, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in a claim, including opinions of treating and other examining sources.[87]
- Consistency. Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.[88]
- Specialization. We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.[89]
- Other factors. When we consider how much weight to give a medical opinion, we will also consider any factors brought to our attention, or of which we are aware, that tend to support or contradict the opinion. For example, the amount of

[86] 20 CFR 404.1527(c)(2)-(c)(2)(ii) and 416.927(c)(2)-(c)(2)(ii).
[87] 20 CFR 404.1527(c)(3) and 416.927(c)(3).
[88] 20 CFR 404.1527(c)(4) and 416.927(c)(4).
[89] 20 CFR 404.1527(c)(5) and 416.927(c)(5).

> understanding of our disability programs and their evidentiary requirements that an AMS has, regardless of the source of that understanding, and the extent to which an AMS is familiar with the other information in a case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.[90]

In addition to weighing all medical opinions and administrative findings of fact with these factors, our rules include special policies for weighing medical opinions from treating sources. We currently define a treating source as an individual's own physician, psychologist, or other AMS who provides, or has provided, medical treatment or evaluation resulting from an ongoing treatment relationship. Generally, we consider a relationship ongoing if the AMS has seen an individual with a frequency consistent with the accepted medical practice for the type of treatment or evaluation required for a specific medical condition(s). We do not consider an AMS to be a treating source if the relationship with the individual is based solely on that individual's need to obtain an assessment or evaluation in support of a disability claim. In such a case, we consider the AMS to be a nontreating source.[91]

Under our current rules, a treating source's medical opinion about the nature and severity of a claimant's impairment(s) is entitled to controlling weight if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record.[92] Stated another

[90] 20 CFR 404.1527(c)(6) and 416.927(c)(6).
[91] 20 CFR 404.1502 and 416.902.
[92] 20 CFR 404.1527(c)(2) and 416.927(c)(2).

way, when we find the supportability and consistency factors persuasive for a treating source, we will generally adopt the treating source's opinion about the nature and severity of a claimant's impairment(s). When we do not give controlling weight to a treating source's medical opinion because it is not well-supported or is inconsistent with other substantial evidence in the case record, we will evaluate the medical opinion using all of the factors listed above.

B. Our current rules about articulating how we consider medical opinions and administrative findings of fact

Once we consider all medical opinions and administrative findings of fact in the record, we articulate how we consider the following medical opinions and administrative findings of fact in the notice of determination or decision:

1. If we give controlling weight to a treating source's medical opinion, we articulate how we considered only that medical opinion by giving good reasons for the weight we give it.[93]
2. If we do not give controlling weight to a treating source's medical opinion, not only do we give good reasons for the weight we give to the treating source's opinion, we also articulate how we considered medical opinions from all AMSs and administrative findings of fact.[94]
3. If we do not give controlling weight to a treating source's medical opinion and we find that an opinion from a medical source who is not an AMS is more persuasive

[93] 20 CFR 404.1527(c)(2) and 416.927(c)(2).
[94] 20 CFR 404.1527(c) and (e) and 416.927(c) and (e).

than the AMS medical opinions and administrative findings of fact, in addition to the requirements listed above, we also articulate how we considered that non-AMS medical opinion.[95]

4. The adjudicator generally should explain the weight given to opinions from other sources when such opinions may have an effect on the outcome of the case.[96]

There is no clear requirement about which factors we must discuss in a determination or decision.

C. History of the controlling weight rule

We based our policies about giving certain treating source opinions controlling weight on the Act's requirement that we make every reasonable effort to obtain from the individual's treating physician (or other treating healthcare provider) all medical evidence necessary to make a disability determination before evaluating medical evidence from a consultative source.[97] Although the Act requires us to consider a treating medical source's evidence, it does not specify how we should evaluate that evidence. Instead, the Act gives us the authority to adopt reasonable and proper rules, regulate and provide for the nature and extent of proof and evidence for disability claims.[98] As the United States Supreme Court has emphasized, we have exceptionally broad statutory authority to establish rules about evidence.[99]

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[95] SSR 06-03p.
[96] Id.
[97] 42 U.S.C. 423(d)(5)(B) and 1382c(H)(i).
[98] 42 U.S.C. 405(a).
[99] Bowen v. Yuckert, 482 U.S. 137, 145 (1987).

Responding to certain court decisions,[100] in 1991 we issued final rules to create a uniform national policy about how to consider medical opinions from treating physicians.[101] We stated that treating sources' evidence tends to have a special, intrinsic value because treating sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of a claimant's medical impairment(s) and may bring a unique perspective to the medical evidence. [102] We also stated that, because medical opinions always have a subjective component and the effects of medical conditions on individuals vary widely, as no two cases are exactly alike, it is not possible to create rules that prescribe the weight to be given to each piece of evidence we may take into consideration. The 1991 final rule also recognized that the weighing of any evidence, including medical opinions, is a process of comparing the intrinsic value, persuasiveness, and internal consistency of each piece of evidence together to determine which findings of fact the evidence best supports.[103]

We have revised our policies about weighing medical opinions from treating sources several times since the 1991 final rules. We expanded the definition of who can be a treating source to allow any AMS to be a treating source and expanded the list of AMSs to include osteopaths, optometrists, podiatrists, and speech-language

[100] See, e.g., Schisler v. Bowen, 851 F.2d 43, 44 (2d Cir. 1988).
[101] 56 FR 36932 (Aug. 1, 1991).
[102] 56 FR at 36934 and 36961.
[103] Id. at 36934-36935.

pathologists.[104] By expanding the AMS list, it became more common for claims to include medical opinions from multiple treating sources. In addition, claimants frequently submitted opinions from medical sources who were not AMSs and not considered treating sources under our rules.

We also issued two SSRs to help adjudicators evaluate multiple medical opinions and opinions from sources who were not AMSs. We issued SSR 96-2p to clarify how we apply this policy and to explain terms in our regulations used in evaluating whether treating source medical opinions are entitled to controlling weight.[105] We emphasized several policies, including:

- A case cannot be decided by relying on a medical opinion if the medical source making that opinion does not provide reasonable support for the opinion.
- Controlling weight may be given only to medical opinions that are about the nature and severity of an individual's impairment(s).
- Controlling weight may not be given to a treating source's medical opinion unless the opinion is both well supported by medically acceptable clinical and laboratory diagnostic techniques (clinical signs and laboratory findings) and not inconsistent with the other substantial evidence in the case record.
- To give a treating source’s opinion controlling weight means to adopt it.

[104] Medical and Other Evidence of Your Impairments and Definition of Medical Consultant, 65 FR 34952 (June 1, 2000); Optometrists as “Accepted Medical Sources” to Establish a Medically Determinable Impairment, 72 FR 9239 (March 1, 2007).
[105] SSR 96-2p: Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions, 61 FR 34490 (July 2, 1996).

- A finding that a treating source's medical opinion is not entitled to controlling weight does not mean that we reject the opinion. It may still be entitled to deference and an adjudicator may adopt it.

We recognized a need to provide additional policy guidance because our rules did not explicitly tell our adjudicators how to consider the growing prevalence of opinions from claimants' medical sources who did not qualify as treating sources under our regulations. We stated this additional policy guidance in SSR 06-03p.[106] SSR 06-03p included the following guidance:

- We may use evidence from medical sources who are not AMSs to show the severity of an impairment(s) and how it affects a claimant's ability to function, but we may not use evidence from medical sources who are not AMSs to establish the existence of an impairment(s) at step 2 of the sequential evaluation process.
- We should evaluate opinions from non-AMS sources using the same criteria used to evaluate AMS opinions.
- We generally should explain the weight given to opinions from non-AMS sources when such opinions may have an effect on the outcome of the case.
- We will explain how we considered an opinion from a non-AMS source when it is entitled to greater weight than a medical opinion from a treating source.

D. Experience with the current rules for weighing medical opinions

[106] SSR 06-03p: Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies, 71 FR 45593 (Aug. 9, 2006).

The current policies for weighing medical opinions have resulted in several adjudicative issues.

1. The number of findings required

Our current policies require our adjudicators to make a large number of findings that need to be included in their determinations and decisions. Claims often contain evidence from a great number of medical sources, and each medical source may express several medical opinions.[107] Some claim files contain opinions from ten or more medical sources. Our current rules require adjudicators to articulate the weight given to most of these opinions using the factors listed in 20 CFR 404.1527(c) and 416.927(c). Often, these medical opinions differ, and Federal courts have remanded cases citing failure to weigh properly one of the many medical opinions in a record.

2. Federal court perspectives

Our rules specify that a treating source's opinion is entitled to controlling weight only if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record.

[107] See ACUS Final Report at 14.

Our rules also require us to give good reasons in our notice of determination or decision for the weight we give a treating source's opinion.[108]

However, some courts have questioned ALJs' articulated reasons for not giving treating source opinions controlling weight. They have offered different reasons for rejecting ALJs' articulated explanations for not giving controlling weight to treating source opinions, such as: the treating source opinion is more recent;[109] an ALJ may only discredit claimants' reported pain symptoms using a heightened evidentiary standard;[110] an ALJ may not rely upon prescribed conservative treatment to indicate less severe restrictions.[111]

In effect, these reviewing courts have focused more on whether we sufficiently articulated the weight we gave treating source opinions rather than on whether substantial evidence supports the Commissioner's final decision. As the ACUS Final Report explains, these courts, in reviewing final agency decisions, are reweighing evidence instead of applying the substantial evidence standard of review, which is intended to be highly deferential standard to us.[112]

Some courts have recognized the challenges the treating source rule creates for us during judicial review. The United States Court of Appeals for the Seventh Circuit has

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[108] 20 CFR 404.1527(c)(2) and 416.927(c)(2).
[109] For example, see Winters v. Barnhart, 153 Fed. Appx. 846 (3d Cir. 2005).
[110] For example, see Smolen v. Chater, 80 F.3d 1273, 1281 (9th Cir. 1996).
[111] For example, see Santiago v. Barnhart, 386 F. Supp. 2d 20 (D.P.R. 2005).
[112] ACUS Final Report at 23.

specifically called on us to reexamine the treating physician rule. That court questioned its usefulness and noted that "the weight properly to be given to testimony or other evidence of a treating physician depends on circumstances." [113]

While the Supreme Court has not directly addressed this issue, its unanimous holding in Black & Decker Disability Plan v. Nord,[114] which overturned the Ninth Circuit's attempt to apply the treating physician rule to a different Federal statute, offers insight. The Court cautioned that that the treating physician rule's built-in evidentiary bias in favor of treating physicians may influence treating sources to favor a finding of disabled.[115] ACUS commented:

"The cautionary note sounded by the Supreme Court in Black & Decker applies as well, it would seem, to Social Security's disability benefits programs. Indeed, as detailed in earlier parts of this report, our legal and empirical assessment of SSA's treating physician rule suggests that the rule's 'routine deference' to treating physicians may no longer be warranted."[116]

3. Ninth Circuit's credit-as-true rule

[113] Hofslien v. Barnhart, 439 F.3d 375, 377 (7th Cir. 2006).
[114] 538 U.S. 822, 832 (2003).
[115] Id. at 832; see also Hofslien v. Barnhart, 439 F.3d at 376 noting that a treating physician may bend over backwards to assist a patient in obtaining benefits); Stephens v. Heckler, 766 F.2d 284, 289 (7th Cir. 1985) (noting that a treating physician may want to do a favor for a friend and client and so may too quickly find disability and might also lack appreciation of how one case compares with other related cases, whereas a consulting physician may bring both impartiality and expertise).
[116] ACUS Final Report at 43.

While courts in most circuits typically remand claims to us for further adjudication when they find we erred by not giving controlling weight to treating source opinions, the Ninth Circuit uses a "credit-as-true" rule, which sometimes results in it ordering us to award benefits instead of remanding cases.[117] The Ninth Circuit combines the treating physician rule with its credit-as-true rule in cases in which the court finds:

1. the ALJ failed to provide legally sufficient reasons for rejecting the treating source opinion;
2. there are no other issues that must be resolved before a determination of disability can be made; and
3. it is clear from the record that the ALJ would be required to find the claimant disabled if he or she credited the treating source opinion as true.[118]

Application of the credit-as-true rule prevents us from reconsidering the evidence in the record as a whole and correcting any errors that may exist, effectively supplanting the judgment of our decision makers.

4. Difficulty determining treating source status due to the changing nature of the primary healthcare system

We stated in the 1991 final rules that our basis for creating the treating physician rule was the presumption that a claimant's sole treating physician generally has the

[117] For example, see Garrison v. Colvin, 759 F.3d 995, 1021-1022 (9th Cir. 2014).
[118] Id. For example, see Smolen v. Chater, 80 F.3d 1273, 1292 (9th Cir. 1996).

longitudinal knowledge and a unique perspective about his or her patient's impairments that objective medical evidence alone cannot provide.

However, changes in the national healthcare workforce and in the manner in which many people now receive primary medical care make this presumption less persuasive than when we issued those rules 25 years ago.[119]

One reason our current formulation needs to be revised is that many claimants receive healthcare from coordinated and managed care organizations instead of from one treating AMS. Claimants typically visit multiple medical professionals (such as primary physicians, specialists, and nurse practitioners) in a variety of medical settings (such as managed care and specialty clinics, hospitals, ambulatory care centers, and various public healthcare centers) for their healthcare needs, and less frequently develop a sustained relationship with one treating physician. Similarly, the specialized nature of healthcare delivery means that medical sources are less familiar with claimants' entire medical situation. This is more pronounced for patients with chronic impairments who are often treated by a team of medical sources instead of by one treating medical source. Additionally, many claimants switch medical providers over time to match changes in insurance coverage. [120]

As a result of the current complex healthcare delivery model, adjudicators and courts have attempted to understand what level of medical care would qualify a medical

[119] See ACUS Final Report at 25-27 and footnotes.
[120] See ACUS Final Report at footnotes 220 and 221.

source as a treating source under our current rules. The main source of divergence originates because our rules do not address how to weigh more than one treating source's medical opinion simultaneously. In response, several courts have created varying standards of how we must address opinions from multiple treating sources. Some courts have even considered the following kinds of medical sources to be treating sources:

- physicians "with relatively sporadic treatment relationships" to claimants;[121]
- all members of a healthcare team;[122] and
- a physician who coordinated care among medical sources but who did not personally examine the claimant.[123]

However, these approaches move our adjudication away from looking at the content of the medical opinions and towards weighing treatment relationships against each other. About these kinds of court holdings, ACUS stated:

> These cases reveal that, from the courts' perspective, the distinction between treating and other physicians has blurred. The expansion of treating physician status runs the risk of undermining the rule itself. The original idea that the persuasiveness of medical opinion should turn more on the frequency of visits and depth of professional judgment underlying the medical opinion has gotten lost.

[121] ACUS Final Report at 34. For example, see Johnson v. Astrue, 597 F.3d 409, 411 (1st Cir. 2009).
[122] For example, see Shontos v. Barnhart, 328 F.3d 418, 426 (8th Cir. 2003).
[123] For example, see Benton v. Barnhart, 331 F.3d 1030 (9th Cir. 2003).

> This blurring of professional lines—between treating physicians and other medical professionals—is, moreover, increasingly reflected not just in judicial opinions, but in medical offices as well. Indeed, the treating physician business has expanded with new services to include doctors who see patients in high volume…. This "devaluation" of the physician-patient relationship calls into further question whether any deference—let alone "controlling weight"—should be afforded to the opinions of this type of medical practitioner.[124]

5. Legal scholars' perspectives on the treating physician rule

Some legal scholars also disfavor the treating physician rule. For example, two scholars argue that "[t]he substantial evidence standard of review should mean the same thing under the Social Security Act as it does under the APA or other organic statutes," but that this rule influences courts to review our decisions differently.[125]

E. Proposed revisions about how to consider medical opinions and prior administrative medical findings

To address the concerns discussed above, we propose several revisions to how we consider medical opinions and prior administrative medical findings. First, we would no

[124] ACUS Final Report at 35 (internal citations omitted).
[125] Richard E. Levy & Robert L. Glicksman, Agency-Specific Precedents, 89 TEX. L. REV. 499, 546 (2011); see also Richard Pierce, Jr., Petition for Rulemaking before the Social Security Administration, July 2, 2012, available at www.regulations.gov by searching under Docket SSA-2012-0035.

longer give a specific weight to medical opinions and prior administrative medical findings; this includes giving controlling weight to medical opinions from treating sources. Instead, we would consider the persuasiveness of medical opinions and prior administrative medical findings using the factors described below. Second, we propose to consider supportability and consistency as the most important factors. Finally, we propose to reorganize the factors to: (1) list the supportability and consistency factors first, (2) include a "relationship with the claimant" factor that combines the content of the current examining relationship and treatment relationship factors, (3) list individually the three different factors currently combined as other factors, and (4) restate the factors using consistent sentence structure.

First, we would consider the persuasiveness of medical opinions and prior administrative medical findings from all medical sources equally using the factors discussed below. We would not defer or give any specific evidentiary weight, including controlling weight, to any prior administrative medical finding or medical opinion, including from an individual's own healthcare providers. We would add this in proposed new 20 CFR 404.1520c(a) and 416.920c(a).

We also propose to focus on the persuasiveness of medical opinions and prior administrative medical findings instead of the weight of an opinion. We always strive to make our regulations as clear as possible; therefore, we are agreeing with an ACUS recommendation to revise the regulations to avoid using terms or phrases that have

different meanings in related contexts.[126] Our current rules use the terms "weigh" or "weight" in several different ways: (1) as a synonym for considering all evidence generally,[127] (2) as a synonym for persuasiveness,[128] and (3) as part of our additional evidence standard for review used at the AC,[129] and during CDRs.[130] In addition to proposing to use the term "persuasive" instead of "weight" for medical opinions in 20 CFR 404.1520c and 416.920c, we also propose to use the term "consider" instead of "weigh" in 20 CFR 404.1520b and 416.920b. We would retain the current standards for AC review and CDRs.

Next, to rely more upon the content and less on the source of medical opinions and prior administrative medical findings, we propose to emphasize supportability and consistency as the most important factors for considering the value and persuasiveness of medical opinions and prior administrative medical findings. The supportability and consistency factors are the two factors that focus upon the objective medical evidence and medical reports supporting a medical opinion or prior administrative medical finding.

[126] ACUS Final Report at 56.
[127] See 20 CFR 404.1520b and 416.920b. This term applies to all evidence, not only medical opinions.
[128] See 20 CFR 404.1527(c) and 416.927(c). See also 56 FR 36931, 36935-36: "[B]ecause opinions always have a subjective component, because the effects of medical conditions on individuals vary so widely, and because no two cases are ever exactly alike, it is not possible to create rules that prescribe the weight to be given to each piece of evidence that we may take into consideration in every case. [The final rule] also recognizes that the weighing of any evidence, including opinions, is a process of comparing the intrinsic value, persuasiveness, and internal consistency of each piece of evidence together to determine which findings of fact are best supported by all of the evidence."
[129] See 20 CFR 404.970(b) and 416.1470(b).
[130] See 20 CFR 404.1579(b)(4), 404.1594(b)(6), 416.979(b)(4), 416.994(b)(1)(vi), and 416.994a(a)(2).

These two factors are also the factors we evaluate when assigning controlling weight under our current rules.[131] If a medical opinion or prior administrative medical finding is both well-supported and consistent with the other evidence in the case record, we typically find that it is persuasive. Under the proposed change, adjudicators would still consider the value of the medical opinion or prior administrative medical finding to the issues in the claim.

Additionally, we propose several revisions to how we list and define the factors considering medical opinion and administrative finding of fact. The most important factors are supportability and consistency; therefore, we propose to list them first. We propose to list the remaining factors after the supportability and consistency factors in an order similar to how they appear in our current rules.

We also propose to merge the current examining relationship and treatment relationship factors into one factor called "relationship with the claimant" because they both describe aspects of the relationship between a claimant and medical source. The proposed factor called "relationship with the claimant" would list the following subfactors separately: examining relationship, length of the treatment relationship, frequency of examination, purpose of treatment relationship, and extent of the treatment relationship.

[131] See 20 CFR 404.1527(c)(2) and 416.927(c)(2).

Similarly, we propose to list separately the three factors we currently identify as other factors: (1) familiarity with the entire record, (2) understanding of our policy, and (3) any other factor brought to our attention. Finally, we propose to restate the factors using consistent sentence structure for clarity.

We would make these revisions in the proposed new 20 CFR 404.1520c and 416.920c.

F. Proposed revisions about how to articulate how we consider medical opinions and prior administrative medical findings

We propose to articulate in our determinations and decisions how we consider medical opinions and prior administrative medical findings at the source level instead of by the date of treatment and to focus more on the content than on the source of this evidence. We also propose to focus on the value and persuasiveness of medical opinions and prior administrative medical findings instead of assigning a specific weight. We propose to add the articulation policies in SSR 06-03p to our regulations and remove our policies about articulating medical opinions from treating sources from our rules. The proposed revisions would make our rules easier to understand and apply. We will continue to consider all evidence we receive in a claim.

First, we propose to articulate together, instead of individually, all medical opinions and prior administrative medical findings made by a medical source because our

administrative experience shows that adjudicators, claimants, representatives, and courts tend to evaluate all of a medical source's evidence together. Additionally, because many claims have voluminous case records containing many types of evidence from different sources, it is not administratively feasible for us to articulate in each determination or decision how we considered all of the factors for all of the medical opinions and prior administrative medical findings. Therefore, we propose that our adjudicators articulate separately how they considered multiple medical opinions or prior administrative medical findings from one medical source.

Second, we propose to simplify our rules about which medical sources' medical opinions we would need to articulate. Because many claims have voluminous case records, it is not administratively feasible for us to articulate in determinations or decisions how we considered all medical sources' medical opinions in a claim. Our current policy requires us to articulate how we considered all AMS medical opinions when controlling weight does not apply, but it does not require us to always articulate how we considered medical opinions from medical sources who are not AMSs.

Due to the advanced education and training received by AMSs, their medical opinions may have presumptive value in describing a claimant's functional limitations and abilities. Therefore, we propose to require our adjudicators to articulate how persuasive they find all AMS medical opinions.

Similarly, because all MCs and PCs are AMSs, we would require our adjudicators to articulate how persuasive they find the prior administrative medical findings in the case record. This requirement is similar to our current policy in SSR 06-03p.

Under these proposed rules, if an adjudicator finds that a medical opinion(s) from a medical source who is not an AMS is more valuable and persuasive than all of the AMS medical opinions and prior administrative medical findings in the claim, then the adjudicator would articulate how he or she considered that medical opinion(s). For example, if a physical therapist submits evidence indicating functional limitations supported by objective medical evidence that is consistent with the other evidence in the claim, the adjudicator would articulate in the determination or decisions how he or she considered that evidence if it is more valuable and persuasive than the all of the other medical opinions and prior administrative medical findings in the claim.

This proposed rule also gives adjudicators the discretion of whether to discuss non-AMS medical opinions they find are not valuable or persuasive. For example, if a physical therapist submits a form indicating functional limitations without sufficient support or that are not consistent with the other evidence in the claim, the adjudicator would have the discretion about whether to articulate in the determination or decisions how he or she considered that evidence.

Third, we propose to specify which of the factors we must articulate in our determinations and decisions. Due to voluminous case records in some cases, it is not

always administratively feasible for us to articulate how we considered each of the factors for all of the medical opinions and prior administrative medical findings in a claim while still offering timely customer service to our claimants. Instead, for AMS medical opinions and prior administrative medical findings, we would explain, in the determination or decision, how we considered the factors of supportability and consistency because those are the most important factors.

Generally, under these proposed rules, we would have discretion to articulate how we consider the other factors. We would only be required to explain how we consider other applicable factors when we find that two or more AMS' medical opinions or prior administrative medical findings about the same issue are not the same but are both equally well-supported and consistent with the other evidence in the record. This situation may arise when the medical sources are discussing different impairments.

Similarly, if we find that a non-AMS medical opinion(s) is well-supported and consistent with the other evidence in the record, as well as more valuable and persuasive than all AMS medical opinions and prior administrative medical findings, we would articulate how we consider the factors of supportability, consistency, and, if any, the other most persuasive factors.

We would add these revisions in the proposed new 20 CFR 404.1520c and 416.920c.

VII. Other revisions related to treating sources

A. Background

Our current regulations use the terms treating source and nontreating source in several sections. We consider a nontreating source to be a physician, psychologist, or other AMS who has examined an individual but does not, or did not, have an ongoing treatment relationship with that individual. The term includes an AMS who is a consultative examiner for us, when the consultative examiner is not the individual's treating source.[132]

In addition to our rules about weighing medical opinions, our current rules include treating sources in two other contexts. First, we state that a claimant's treating source will be the preferred source of a consultative examination when, in our judgment, the treating source is qualified, equipped, and willing to perform the additional examination or tests for the fee schedule payment, and generally furnishes complete and timely reports.[133] We also state that we will use a medical source other than the treating source for a consultative examination in other situations, such as if there are conflicts or inconsistencies in a claim that cannot be resolved by going back to the treating source.[134]

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[132] See 20 CFR 404.1502 and 416.902.
[133] 20 CFR 404.1519h and 416.919h.
[134] 20 CFR 404.1519i and 416.919i.

The other context in which we use the term treating source is when a claimant must follow treatment prescribed by his or her physician if the treatment can restore the claimant's ability to work.[135] Our subregulatory policy recognizes prescribed treatment from a claimant's treating sources.

B. Proposed revisions

The current healthcare delivery model involves many types of medical sources that are not currently AMSs and that we do not consider treating sources under our rules. A challenge has been the difference between our policy-specific intent for the term "treating source" and its colloquial use to refer to any medical source who has treated an individual.

We are proposing to align our rules to focus more on the content of medical evidence than the source of that evidence. We propose to consider all medical sources that a claimant identifies as his or her medical sources for our rules and not use the term "treating source" in our regulations at all. Consequently, we propose to revise our rules to use the phrase "your medical source(s)" to refer to whichever medical sources a claimant chooses to use.

[135] 20 CFR 404.1530 and 416.930.

First, we propose to revise our regulations at 20 CFR 404.1530(a) and 416.930(a) to state that a claimant must follow treatment by his or her medical source(s) if this treatment can restore his or her ability to work.

Second, we propose to revise our rules to state that our preference for consultative examinations will be any of a claimant's medical sources. We would continue to use the existing standards to decide whether to select the claimant's medical source for the consultative examinations, such as whether the medical source is qualified, equipped, and willing to perform the additional examination or tests for the fee schedule payment, and generally furnishes complete and timely reports. We propose to make this revision to 20 CFR 404.1519h, 404.1519i, 416.919h, and 416.919i. We also propose to delete the final sentence of current 20 CFR 404.1519h and 416.919h that discusses which medical source may perform supplemental tests because this is already encompassed in the prior sentence's use of the term "test(s)."

Finally, because we would no longer use the terms treating source and nontreating source in our regulations, we propose to delete the definitions for these terms from our regulations at 20 CFR 404.1502 and 416.902.

VIII. Reorganizing our opinion evidence regulations

Our current regulations about opinion evidence are scattered throughout 20 CFR part 404 subpart P and part 416 subpart I. As part of our proposal to simplify our opinion

evidence regulations to make them easier to understand and use, we are proposing to reorganize several sections and rename some section headings in our regulations. The proposed reorganization would combine similar topics now in separate sections into one section, place sections about how we weigh medical opinions and how we consider evidence next to each other, and add a section about establishing an impairment(s) at step 2 of the sequential evaluation process.

For ease of use, the following are distribution and derivation tables for 20 CFR part 404 subpart P and part 416 subpart I:

A. Distribution table

Current section	Proposed section
404.1501- 404.1506	404.1501- 404.1506
404.1508	404.1521
404.1509-404.1511	404.1509-404.1511
404.1512(a)	404.1512(a)(1)
404.1512(b)-(b)(1)(iv)	404.1513(a)-(a)(4)
404.1512(b)(1)(v)	404.1520b(c)(2)
404.1512(b)(1)(vi)-(viii)	404.1513(a)(5)-(a)(5)(vi)
404.1512(b)(2)-(b)(2)(iv)	404.1513(b)-(b)(2)
404.1512(c)-(c)(7)	404.1512(a)(1)-(a)(1)(vii)
404.1512(d)-(f)	404.1512(b)(1)-(b)(3)
404.1513(a)	404.1502(a)

404.1513(b)-(b)(2)	404.1513(a)-(a)(2)
404.1513(c)-(c)(2)	Remove
404.1513(d)-(d)(4)	404.1513(a)(4)
404.1513(e)-(e)(3)	404.1512(a)(2)-(a)(2)(iii)
404.1514-404.1520b	404.1514-404.1520b
404.1521	404.1522
404.1522	404.1523(a) and (b)
404.1523	404.1523(c)
404.1525-404.1526	404.1525-404.1526
404.1527(a)(1)	Remove
404.1527(a)(2)	404.1513(a)(3)
404.1527(b)	404.1527(b)
404.1527(c)-(c)(6)	404.1520c(b)-(b)(7) and 404.1527(c)-(c)(6)
404.1527(d)-(d)(3)	404.1520b(c)(3)-(c)(3)(vii) and 404.1527(d)-(d)(3)
404.1527(e)-(e)(3)	404.1513(b)(3) and 404.1513a
404.1528	404.1502
404.1529-Appendix 2 to Subpart P of Part 404	404.1529-Appendix 2 to Subpart P of Part 404
416.901- 416.906	416.901- 416.906
416.908	416.921

416.909-416.911	416.909-416.911
416.912(a)	416.912(a)(1)
404.912(b)-(b)(1)(iv)	404.913(a)-(a)(4)
404.912(b)(1)(v)	404.920b(c)(2)
404.912(b)(1)(vi)-(viii)	404.913(a)(5)-(a)(5)(vi)
416.912(b)(2)-(b)(2)(iv)	416.913(b)-(b)(2)
416.912(c)-(c)(7)	416.912(a)(1)-(a)(1)(vii)
416.912(d)-(f)	416.912(b)(1)-(b)(3)
416.913(a)	416.902(a)
416.913(b)-(b)(2)	416.913(a)-(a)(2)
416.913(c)-(c)(2)	Remove
416.913(d)-(d)(4)	416.913(a)(4)
416.913(e)-(e)(3)	416.912(a)(2)-(a)(2)(iii)
416.913(f)	416.912(a)(3)
416.914-416.920b	416.914-416.920b
416.923	416.923(c)
416.925-416.926	416.925-416.926
416.927(a)(1)	Remove
416.927(a)(2)	416.913(a)(3)
416.927(b)	416.927(b)
416.927(c)-(c)(6)	416.920c(b)-(b)(7) and 416.927(c)-(c)(6)

416.927(d)-(d)(3)	416.920b(c)(3)-(c)(3)(vii) and 416.927(d)-(d)(3)
416.927(e)-(e)(3)	416.913(b)(3) and 416.913a
416.928	416.902
416.929-416.999d	416.929-416.999d

B. Derivation Table

Proposed section	Current section
404.1501	404.1501
404.1502(a)	404.1513(a)
404.1502(b)-404.1503a	404.1502-404.1503a and 404.1528
404.1504-404.1507	404.1504-404.1507
[Reserved]	404.1508
404.1509-404.1511	404.1509-404.1511
404.1512(a)(1)	404.1512(a)
404.1512(a)(1)-(a)(1)(vii)	404.1512(c)-(c)(7)
404.1512(a)(2)-(a)(2)(iii)	404.1513(e)-(e)(3)
404.1512(b)(1)-(b)(3)	404.1512(d)-(f)
404.1513(a)-(a)(2)	404.1512(b)(1)(i)-(b)(1)(ii)
404.1513(a)(3)-(a)(3)(iv)	404.1527(a)(2)
404.1513(a)(4)	404.1512(b)(1)(iii)-(iv) and 404.1513(d)-(d)(4)

404.1513(a)(5)-(a)(5)(v)	404.1512(b)-(b)(1)(viii)
404.1513(b)-(b)(2)	404.1512(b)(2)-(b)(2)(iv)
404.1513a	404.1527(e)-(e)(3)
404.1514-404.1520b	404.1514-404.1520b
404.1520b(c)(1)	404.1512(b)(5)
404.1520b(c)(2)	404.1527(d)-(d)(3)
404.1520b(c)(3)	404.1527(e)(1)(i)
404.1520c(b)-(b)(7)	404.1527(c)-(c)(6)
404.1521	404.1508
404.1522	404.1521
404.1523(a) and (b)	404.1522
404.1523(c)	404.1523
404.1525-404.1526	404.1525-404.1526
404.1527	404.1527
[Reserved]	404.1528
404.1529- Appendix 2 to Subpart P of Part 404	404.1529- Appendix 2 to Subpart P of Part 404
416.901	416.901
416.902(a)	416.913(a)
416.902(b)-416.903a	416.902-416.903a and 416.928
416.904-416.907	416.904-416.907
[Reserved]	416.908

416.909-416.911	416.909-416.911
416.912(a)(1)	416.912(a)
416.912(a)(1)-(a)(1)(vii)	416.912(c)-(c)(7)
416.912(a)(2)-(a)(2)(iii)	416.913(e)-(e)(3)
416.912(a)(3)	416.913(f)
416.912(b)(1)-(b)(3)	416.912(d)-(f)
416.913(a)-(a)(2)	416.912(b)(1)(i)-(b)(1)(ii)
416.913(a)(3)-(a)(3)(iv)	416.927(a)(2)
416.913(a)(4)	416.912(b)(1)(iii)-(iv) and 416.913(d)-(d)(4)
416.913(a)(5)-(a)(5)(v)	416.912(b)-(b)(1)(viii)
416.913(b)-(b)(2)	416.912(b)(2)-(b)(2)(iv)
416.913(b)(2)	New
416.913a	416.927(e)-(e)(3)
416.914-416.920b	416.914-416.920b
416.920b(c)(1)	416.912(b)(5)
416.920b(c)(2)	416.927(d)-(d)(3)
416.920b(c)(3)	416.927(e)(1)(i)
416.920c(b)-(b)(7)	416.927(c)-(c)(6)
416.921	416.908
416.922	416.921
416.923(a) and (b)	416.922

416.923(c)	416.923
416.925-416.926	416.925-416.926
416.927	416.927
[Reserved]	416.928
416.929-416.999d	416.928-416.999d

We also propose to reorganize the current text within 20 CFR 404.1520b and 416.920b for readability. Finally, we propose to make a number of revisions throughout the proposed regulatory sections to use plain language.

IX. Effect upon certain Social Security Rulings

Upon publication of final rules, we would also rescind the following SSRs that would be inconsistent or unnecessarily duplicative with our new rules:

- SSR 96-2p: Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions.[136]
- SSR 96-5p: Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner.[137]
- SSR 96-6p: Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program

[136] 61 FR 34490 (July 2, 1996).
[137] 61 FR 34471 (July 2, 1996).

Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence.[138]

- SSR 06-03p: Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies.[139]

In addition, because we would rescind SSR 96-6p, we intend to publish a new SSR that would discuss certain aspects of how ALJs and the AC must obtain evidence sufficient to make a finding of medical equivalence.

X. Proposed implementation process

We propose to implement all of the revisions discussed above on the effective date of the final rule, with the exception of those revisions specified below. The revisions that we propose to implement in all claims as of the effective date of the final rule respond fully to the mandate of BBA section 832 medical review requirements, clarify current policy, or are not substantially related to the policies about evaluating medical opinions.

[138] 61 FR 34466 (July 2, 1996).

However, a claimant has the burden of proving to us that he or she is blind or disabled, and we are aware that claimants whose claims are pending administrative review may have requested and obtained treating and other medical source opinions based on our policy set forth in current 20 CFR 404.1527 and 416.927. Considering this fact, we propose to continue to use our current rules about how we consider medical source opinion evidence, including the controlling weight policy for treating sources, for claims that are filed before the effective date of the final rule. Using our current rules about how we consider medical source opinions for claims filed before the effective date of the final rule will also enable us to apply a uniform standard to evaluate medical source opinion evidence throughout the administrative review process.

Specifically, we propose to continue to use the following current rules in claims that are filed before the effective date of the final rule:

- The current definitions of a medical opinion and a treating source in current 20 CFR 404.1502, 404.1527(a), 416.902, and 416.927(a);
- How we consider medical opinions, including that we may give controlling weight to certain medical opinions, as explained in current 20 CFR 404.1527(b)-(c) and 416.927(b)-(c);
- How we consider issues reserved to the Commissioner, as explained in current 20 CFR 404.1527(d) and 416.927(d);
- How we consider decisions by other governmental agencies and nongovernmental entities, as explained in current 20 CFR 404.1504 and 416.904; and

- Neither audiologists nor APRNs are AMSs, as explained in current 20 CFR 404.1502, 404.1513, 416.902, and 416.913.

We also propose to make a number of conforming changes to reflect this proposed implementation process.

Executive Order 12866, as supplemented by Executive Order 13563

We consulted with the Office of Management and Budget (OMB) and determined that this NPRM meets the criteria for a significant regulatory action under Executive Order 12866, as supplemented by Executive Order 13563. Therefore, OMB reviewed it.

Regulatory Flexibility Act

We certify that this NPRM would not have a significant economic impact on a substantial number of small entities because it affects individuals only. Therefore, a regulatory flexibility analysis is not required under the Regulatory Flexibility Act, as amended.

Paperwork Reduction Act

These rules do not create any new or affect any existing collections and, therefore, do not require OMB approval under the Paperwork Reduction Act.

(Catalog of Federal Domestic Assistance Program Nos. 96.001, Social Security – Disability Insurance; 96.002, Social Security – Retirement Insurance; and 96.004, Social

Security – Survivors Insurance)

List of subjects

20 CFR Part 404

Administrative practice and procedure, Blind, Disability benefits, Old-Age, Survivors, and Disability Insurance, Reporting and recordkeeping requirements, Social Security.

20 CFR Part 416

Administrative practice and procedure, Reporting and recordkeeping requirements, Supplemental Security Income (SSI).

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Carolyn W. Colvin,
Acting Commissioner of Social Security.

For the reasons set out in the preamble, we propose to amend 20 CFR parts 404 416 as set forth below:

PART 404—FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE (1950-)

Subpart J—Determinations, Administrative Review Process, and Reopening of Determinations and Decisions

1. The authority citation for subpart J of part 404 continues to read as follows:

Authority: Secs. 201(j), 204(f), 205(a)-(b), (d)-(h), and (j), 221, 223(i), 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 401(j), 404(f), 405(a)-(b), (d)-(h), and (j), 421, 423(i), 425, and 902(a)(5)); sec. 5, Pub. L. 97-455, 96 Stat. 2500 (42 U.S.C. 405 note); secs. 5, 6(c)-(e), and 15, Pub. L. 98-460, 98 Stat. 1802 (42 U.S.C. 421 note); sec. 202, Pub. L. 108-203, 118 Stat. 509 (42 U.S.C. 902 note).

2. In § 404.906, revise the fourth sentence of paragraph (b)(2) to read as follows:

§ 404.906 Testing modifications to the disability determination procedures.

* * * * *

(b) * * *

(2) * * * However, before an initial determination is made in any case where there is evidence which indicates the existence of a mental impairment, the decisionmaker will

make every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment pursuant to our existing procedures (see §404.1617). * * *

* * * * *

3. In § 404.942, revise paragraph (f)(1) to read as follows:

§ 404.942 Prehearing proceedings and decisions by attorney advisors.

* * * * *

(f) * * *

(1) Authorize an attorney advisor to exercise the functions performed by an administrative law judge under §§404.1513a , 404.1520a, 404.1526, and 404.1546.

* * * * *

Subpart P—Determining Disability and Blindness

4. The authority citation for subpart P of part 404 is revised to read as follows:

Authority: Secs. 202, 205(a)-(b) and (d)–(h), 216(i), 221(a) and (h)-(j), 222(c), 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 405(a)-(b) and (d)–(h), 416(i), 421(a) and (h)-(j), 422(c), 423, 425, and 902(a)(5)); sec. 211(b), Pub. L. 104–193, 110 Stat. 2105, 2189; sec. 202, Pub. L. 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

5. Revise § 404.1502 to read as follows:

§ 404.1502 Definitions for this subpart.

As used in the subpart—

(a) Acceptable medical source means a medical source who is a:

(1) Licensed physician (medical or osteopathic doctor);

(2) Licensed psychologist, which includes:

(i) A licensed or certified psychologist at the independent practice level, or

(ii) A licensed or certified school psychologist, or other licensed or certified individual with another title who performs the same function as a school psychologist in a school setting, for impairments of intellectual disability, learning disabilities, and borderline intellectual functioning only;

(3) Licensed optometrist for impairments of visual disorders only (except, in Puerto Rico, for the measurement of visual acuity and visual fields only);

(4) Licensed podiatrist for impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle;

(5) Qualified speech-language pathologist for speech or language impairments only. For this source, qualified means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of Clinical Competence in Speech-Language Pathology from the American Speech-Language-Hearing Association;

(6) Licensed audiologist for impairments of hearing loss and auditory processing disorders only (only with respect to claims filed (see §404.614) on or after [EFFECTIVE DATE OF FINAL RULE]); or

(7) Licensed Advanced Practice Registered Nurse or other licensed advanced practice nurse with another title for impairments within his or her licensed scope of practice (only with respect to claims filed (see §404.614) on or after [EFFECTIVE DATE OF FINAL RULE]).

(b) Commissioner means the Commissioner of Social Security or his or her authorized designee.

(c) Laboratory findings means anatomical, physiological, or psychological phenomena that can be shown by the use of medically acceptable laboratory diagnostic techniques. Diagnostic techniques include chemical tests (such as blood tests), electrophysiological studies (such as electrocardiograms and electroencephalograms), medical imaging (such as X-rays), and psychological tests.

(d) Medical source means an individual who is licensed as a healthcare worker by a State and working within the scope of practice permitted under State or Federal law, or an individual who is certified by a State as a speech-language pathologist or a school psychologist and acting within the scope of practice permitted under State or Federal law.

(e) Nonmedical source means a source of evidence who is not a medical source. This includes, but is not limited to,:

(1) You;

(2) Educational personnel (for example, school teachers, counselors, early intervention team members, developmental center workers, and daycare center workers);

(3) Public and private social welfare agency personnel; and

(4) Family members, caregivers, friends, neighbors, employers, and clergy.

(f) Objective medical evidence means signs, laboratory findings, or both.

(g) Signs means anatomical, physiological, or psychological abnormalities that can be observed, apart from your statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, e.g., abnormalities of behavior, mood, thought, memory, orientation, development, or perception and must also be shown by observable facts that can be medically described and evaluated.

(h) State agency means an agency of a State designated by that State to carry out the disability or blindness determination function.

(i) Symptoms means your own description of your physical or mental impairment.

(j) We or us means, as appropriate, either the Social Security Administration or the State agency making the disability or blindness determination.

(k) You or your means, as appropriate, the person who applies for benefits or for a period of disability, the person for whom an application is filed, or the person who is receiving benefits based on disability or blindness.

§ 404.1503 [Amended]

6. In § 404.1503, remove paragraph (e).

7. Revise § 404.1504 to read as follows:

§ 404.1504 Decisions by other governmental agencies and nongovernmental entities.

Other governmental agencies and nongovernmental entities-- such as the Department of Veterans Affairs, the Department of Defense, the Department of Labor,

the Office of Personnel Management, State agencies, and private insurers-- make disability, blindness, employability, Medicaid, workers' compensation, and other benefits decisions for their own programs using their own rules. Because a decision by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits is based on its rules, it is not binding on us and is not our decision about whether you are disabled or blind under our rules. Therefore, in claims filed (see §404.614) on or after [EFFECTIVE DATE OF FINAL RULE], we will not provide any analysis in our determination or decision about a decision made by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits. However, we will consider in our determination or decision relevant supporting evidence underlying the other governmental agency or nongovernmental entity's decision that we receive as evidence in your claim.

§ 404.1508 [Removed and Reserved]

8. Remove and reserve § 404.1508:

9. Revise § 404.1512 to read as follows:

§ 404.1512 Responsibility for evidence.

(a) Your responsibility—(1) General. In general, you have to prove to us that you are blind or disabled. You must inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled (see § 404.1513). This duty is ongoing and requires you to disclose any additional related evidence about which you

become aware. This duty applies at each level of the administrative review process, including the Appeals Council level if the evidence relates to the period on or before the date of the administrative law judge hearing decision. We will consider only impairment(s) you say you have or about which we receive evidence. When you submit evidence received from another source, you must submit that evidence in its entirety, unless you previously submitted the same evidence to us or we instruct you otherwise. If we ask you, you must inform us about:

(i) Your medical source(s);

(ii) Your age;

(iii) Your education and training;

(iv) Your work experience;

(v) Your daily activities both before and after the date you say that you became disabled;

(vi) Your efforts to work; and

(vii) Any other factors showing how your impairment(s) affects your ability to work. In §§404.1560 through 404.1569, we discuss in more detail the evidence we need when we consider vocational factors.

(2) Completeness. The evidence in your case record must be complete and detailed enough to allow us to make a determination or decision about whether you are disabled or blind. It must allow us to determine—

(i) The nature and severity of your impairment(s) for any period in question;

(ii) Whether the duration requirement described in §404.1509 is met; and

(iii) Your residual functional capacity to do work-related physical and mental activities, when the evaluation steps described in §404.1520(e) or (f)(1) apply.

(b) Our responsibility—(1) Development. Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical reports from your own medical sources and entities that maintain your medical sources' evidence when you give us permission to request the reports.

(i) Every reasonable effort means that we will make an initial request for evidence from your medical source or entity that maintains your medical source's evidence, and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one follow-up request to obtain the medical evidence necessary to make a determination. The medical source or entity that maintains your medical source's evidence will have a minimum of 10 calendar days from the date of our follow-up request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case.

(ii) Complete medical history means the records of your medical source(s) covering at least the 12 months preceding the month in which you file your application. If you say that your disability began less than 12 months before you filed your application, we will develop your complete medical history beginning with the month you say your disability began unless we have reason to believe your disability began earlier. If

applicable, we will develop your complete medical history for the 12-month period prior to:

(A) The month you were last insured for disability insurance benefits (see §404.130);

(B) The month ending the 7-year period you may have to establish your disability and you are applying for widow's or widower's benefits based on disability (see §404.335(c)(1)); or

(C) The month you attain age 22 and you are applying for child's benefits based on disability (see §404.350(e)).

(2) Obtaining a consultative examination. We may ask you to attend one or more consultative examinations at our expense. See §§404.1517 through 404.1519t for the rules governing the consultative examination process. Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources. We may order a consultative examination while awaiting receipt of medical source evidence in some instances, such as when we know a source is not productive, is uncooperative, or is unable to provide certain tests or procedures. We will not evaluate this evidence until we have made every reasonable effort to obtain evidence from your medical sources.

(3) Other work. In order to determine under §404.1520(g) that you are able to adjust to other work, we must provide evidence about the existence of work in the national economy that you can do (see §§404.1560 through 404.1569a), given your residual functional capacity (which we have already assessed, as described in §404.1520(e)), age, education, and work experience.

10. Revise § 404.1513 to read as follows:

§ 404.1513 Categories of evidence.

(a) What we mean by evidence. Subject to the provisions of paragraph (b), evidence is anything you or anyone else submits to us or that we obtain that relates to your claim. We consider evidence under §§404.1520b, 404.1520c (or under §404.1527 for claims filed (see §404.614) before [EFFECTIVE DATE OF FINAL RULE]). We evaluate evidence we receive according to the rules pertaining to the relevant category of evidence. The categories of evidence are:

(1) Objective medical evidence. Objective medical evidence is medical signs, laboratory findings, or both, as defined in §404.1502(f).

(2) Medical opinions. A medical opinion is a statement from a medical source about what you can still do despite your impairment(s) and whether you have one or more impairment-related limitations or restrictions in the following abilities:

(i) Your ability to perform physical demands of work activities, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping, or crouching);

(ii) Your ability to perform mental demands of work activities, such as understanding; remembering; maintaining concentration, persistence, and pace; carrying out instructions; and responding appropriately to supervision, co-workers, and work pressures in a work setting;

(iii) Your ability to perform other demands of work, such as seeing, hearing, and using other senses; and

(iv) Your ability to adapt to environmental conditions, such as temperature extremes and fumes.

(For claims filed (see §404.614) before [EFFECTIVE DATE OF FINAL RULE]), see §404.1527(a) for the definition of medical opinion.)

(3) Other medical evidence. Other medical evidence is evidence from a medical source that is not objective medical evidence or a medical opinion, including judgments about the nature and severity of your impairments, your medical history, clinical findings, diagnosis, treatment prescribed with response, or prognosis. (For claims filed (see §404.614) before [EFFECTIVE DATE OF FINAL RULE], other medical evidence does not include diagnosis, prognosis, and statements that reflect judgments about the nature and severity of your impairment(s)).

(4) Statements from nonmedical sources. A statement from a nonmedical source is a statement(s) made by nonmedical sources (including you) about your impairment(s), your restrictions, your daily activities, your efforts to work, or any other relevant statements the nonmedical source makes to medical sources during the course of your examination or treatment or that he or she makes to us during interviews, on applications, in reports or letters, and in testimony in our administrative proceedings.

(5) Prior administrative medical findings. 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) based on their review of the evidence in your case record, such as:

(i) The existence and severity of your impairment(s);

(ii) The existence and severity of your symptoms;

(iii) Statements about whether your impairment(s) meets or medically equals any listing in the Listing of Impairments in Part 404, Subpart P, Appendix 1;

(iv) Your residual functional capacity;

(v) Whether your impairment(s) meets the duration requirement; and

(vi) How failure to follow prescribed treatment (see §404.1530) and drug addiction and alcoholism (see §404.1535) relate to your claim.

(b) Exceptions for privileged communications. (1) The privileged communications listed in paragraphs (b)(1)(i) and (ii) of this section are not evidence, and we will neither consider nor provide any analysis about them in your determination or decision. This exception for privileged communications applies equally whether your representative is an attorney or a non-attorney.

(i) Oral or written communications between you and your representative that are subject to the attorney-client privilege, unless you voluntarily disclose the communication to us; or

(ii) Your representative's analysis of your claim, unless he or she voluntarily discloses it to us. This analysis means information that is subject to the attorney work product doctrine, but it does not include medical evidence, medical source opinions, or any other factual matter that we may consider in determining whether or not you are entitled to benefits (see paragraph (b)(2) of this section).

(2) The attorney-client privilege generally protects confidential communications between an attorney and his or her client that are related to providing or obtaining legal advice. The attorney work product doctrine generally protects an attorney's analysis, theories, mental impressions, and notes. In the context of your disability claim, neither the attorney-client privilege nor the attorney work product doctrine allow you to withhold factual information, medical source opinions, or other medical evidence that we may consider in determining whether or not you are entitled to benefits. For example, if you tell your representative about the medical sources you have seen, your representative cannot refuse to disclose the identity of those medical sources to us based on the attorney-client privilege. As another example, if your representative asks a medical source to complete an opinion form related to your impairment(s), symptoms, or limitations, your representative cannot withhold the completed opinion form from us based on the attorney work product doctrine. The attorney work product doctrine would not protect the source's opinions on the completed form, regardless of whether or not your representative used the form in his or her analysis of your claim or made handwritten notes on the face of the report.

11. Add § 404.1513a to read as follows:

§ 404.1513a Evidence from our Federal or State agency medical or psychological consultants.

The following rules apply to our Federal or State agency medical or psychological consultants that we consult in connection with administrative law judge hearings and Appeals Council reviews:

(a) In claims adjudicated by the State agency, a State agency medical or psychological consultant may make the determination of disability together with a State agency disability examiner or provide medical evidence to a State agency disability examiner when the disability examiner makes the initial or reconsideration determination alone (see §404.1615(c) of this part). The following rules apply:

(1) When a State agency medical or psychological consultant makes the determination together with a State agency disability examiner at the initial or reconsideration level of the administrative review process as provided in §404.1615(c)(1), he or she will consider the evidence in your case record and make administrative findings about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or medically equals the requirements for any impairment listed in appendix 1 to this subpart, and your residual functional capacity. These administrative medical findings are based on the evidence in your case but are not in themselves evidence at the level of the administrative review process at which they are made. See §404.1513(a)(5).

(2) When a State agency disability examiner makes the initial determination alone as provided in §404.1615(c)(3), he or she may obtain medical evidence from a State agency medical or psychological consultant about one or more of the medical issues listed in paragraph (a)(1) of this section. In these cases, the State agency disability examiner will consider the medical evidence of the State agency medical or psychological consultant under §§404.1520b and 404.1520c.

(3) When a State agency disability examiner makes a reconsideration determination alone as provided in §404.1615(c)(3), he or she will consider prior administrative medical findings made by a State agency medical or psychological consultant at the initial level of the administrative review process, and any medical evidence provided by such consultants at the initial and reconsideration levels, about one or more of the medical issues listed in paragraph (a)(1)(i) of this section under §§404.1520b and 404.1520c.

(b) Administrative law judges are responsible for reviewing the evidence and making administrative findings of fact and conclusions of law. They will consider prior administrative medical findings and medical evidence from our Federal or State agency medical or psychological consultants as follows:

(1) Administrative law judges are not required to adopt any prior administrative medical findings, but they must consider this evidence according to §§404.1520b and 404.1520c because our Federal or State agency medical or psychological consultants are highly qualified experts in Social Security disability evaluation.

(2) Administrative law judges may also ask for medical evidence from expert medical sources. Administrative law judges will consider this evidence under §§404.1520b and 404.1520c, as appropriate.

(c) When the Appeals Council makes a decision, it will consider prior administrative medical findings according to the same rules for considering prior administrative medical findings as administrative law judges follow under paragraph (b) of this section.

12. In § 404.1518, revise paragraph (c) to read as follows:

§ 404.1518 If you do not appear at a consultative examination.

* * * * *

(c) Objections by your medical source(s). If any of your medical sources tell you that you should not take the examination or test, you should tell us at once. In many cases, we may be able to get the information we need in another way. Your medical source(s) may agree to another type of examination for the same purpose.

13. In § 404.1519g, revise paragraph (a) to read as follows:

§ 404.1519g Who we will select to perform a consultative examination.

(a) We will purchase a consultative examination only from a qualified medical source. The medical source may be your own medical source or another medical source. If you are a child, the medical source we choose may be a pediatrician.

* * * * *

14. Revise § 404.1519h to read as follows:

§ 404.1519h Your medical source.

When, in our judgment, your medical source is qualified, equipped, and willing to perform the additional examination or test(s) for the fee schedule payment, and generally furnishes complete and timely reports, your medical source will be the preferred source for the purchased examination or test(s).

15. Revise § 404.1519i to read as follows:

§ 404.1519i Other sources for consultative examinations.

We will use a different medical source than your medical source for a purchased examination or test in situations including, but not limited to, the following:

(a) Your medical source prefers not to perform such an examination or does not have the equipment to provide the specific data needed;

(b) There are conflicts or inconsistencies in your file that cannot be resolved by going back to your medical source;

(c) You prefer a source other than your medical source and have a good reason for your preference;

(d) We know from prior experience that your medical source may not be a productive source, such as when he or she has consistently failed to provide complete or timely reports; or

(e) Your medical source is not a qualified medical source as defined in §404.1519g.

16. In § 404.1519n, revise paragraph (c)(6) to read as follows:

§ 404.1519n Informing the medical source of examination scheduling, report content, and signature requirements.

* * * * *

(c) * * *

(6) A medical opinion. Although we will ordinarily request a medical opinion as part of the consultative examination process, the absence of a medical opinion in a

consultative examination report will not make the report incomplete. See §404.1513(a)(3); and

* * * * *

17. In § 404.1520a, revise the second sentence of paragraph (b)(1) to read as follows:

§ 404.1520a Evaluation of mental impairments.

* * * * *

(b) * * *

(1) * * * See §404.1521 for more information about what is needed to show a medically determinable impairment. * * *

* * * * *

18. Revise § 404.1520b to read as follows:

§ 404.1520b How we consider evidence.

After we review all of the evidence relevant to your claim, we make findings about what the evidence shows.

(a) Complete and consistent evidence. If all of the evidence we receive, including all medical opinion(s), is consistent and there is sufficient evidence for us to determine whether you are disabled, we will make our determination or decision based on that evidence.

(b) Incomplete or inconsistent evidence. In some situations, we may not be able to make our determination or decision because the evidence in your case record is

insufficient or inconsistent. We consider evidence to be insufficient when it does not contain all the information we need to make our determination or decision. We consider evidence to be inconsistent when it conflicts with other evidence, contains an internal conflict, is ambiguous, or when the medical evidence does not appear to be based on medically acceptable clinical or laboratory diagnostic techniques. If the evidence in your case record is insufficient or inconsistent, we may need to take the additional actions in paragraphs (b)(1) through (4) of this section.

(1) If any of the evidence in your case record, including any medical opinion(s) and prior administrative medical findings, is inconsistent, we will consider the relevant evidence and see if we can determine whether you are disabled based on the evidence we have.

(2) If the evidence is consistent but we have insufficient evidence to determine whether you are disabled, or if after considering the evidence we determine we cannot reach a conclusion about whether you are disabled, we will determine the best way to resolve the inconsistency or insufficiency. The action(s) we take will depend on the nature of the inconsistency or insufficiency. We will try to resolve the inconsistency or insufficiency by taking any one or more of the actions listed in paragraphs (b)(2)(i) through (iv) of this section. We might not take all of the actions listed paragraphs (b)(2)(i) through (iv) of this section. We will consider any additional evidence we receive together with the evidence we already have.

(i) We may recontact your medical source. We may choose not to seek additional evidence or clarification from a medical source if we know from experience that the source either cannot or will not provide the necessary evidence. If we obtain medical

evidence over the telephone, we will send the telephone report to the source for review, signature, and return;

(ii) We may request additional existing evidence;

(iii) We may ask you to undergo a consultative examination at our expense (see §§404.1517 through 404.1519t); or

(iv) We may ask you or others for more information.

(3) When there are inconsistencies in the evidence that we cannot resolve or when, despite efforts to obtain additional evidence, the evidence is insufficient to determine whether you are disabled, we will make a determination or decision based on the evidence we have.

(c) Evidence that is neither valuable nor persuasive. Paragraphs (c)(1) through (3) of this section apply in claims filed (see §404.614) on or after [EFFECTIVE DATE OF FINAL RULE]. Because the evidence listed in paragraphs (c)(1) through (3) is inherently neither valuable nor persuasive to the issue of whether you are disabled or blind under the Act, we will not provide any analysis about how we considered such evidence in our determination or decision, even under §404.1520c:

(1) Decisions by other governmental agencies and nongovernmental entities. See §404.1504.

(2) Disability examiner findings. Findings made by a State agency disability examiner made at a previous level of adjudication about a medical issue, vocational issue, or the ultimate determination about whether you are disabled.

(3) Statements on issues reserved to the Commissioner. The statements listed in paragraphs (c)(3)(i) through (vii) of this section would direct our determination or

decision that you are or are not disabled or blind within the meaning of the Act, but we are responsible for making the determination or decision about whether you are disabled or blind:

(i) Statements that you are or are not disabled, blind, able to work, or able to perform regular or continuing work;

(ii) Statements about whether or not your impairment(s) meets the duration requirement (see §404.1509);

(iii) Statements about whether or not your impairment(s) meets or medically equals any listing in the Listing of Impairments in 20 CFR Part 404, Subpart P, Appendix 1;

(iv) Statements about what your residual functional capacity is using our programmatic terms about the functional exertional levels in Part 404, Subpart P, Appendix 2, Rule 200.00 instead of descriptions about your functional abilities and limitations (see §404.1545);

(v) Statements about whether or not your residual functional capacity prevents you from doing past relevant work (see §404.1560);

(vi) Statements that you do or do not meet the requirements of a medical-vocational rule in Part 404, Subpart P, Appendix 2; and

(vii) Statements about whether or not your disability continues or ends when we conduct a continuing disability review (see §404.1594).

19. Add § 404.1520c to read as follows:

§ 404.1520c How we consider and articulate medical opinions and prior administrative medical findings.

This section applies to claims filed (see §404.614) on or after [EFFECTIVE DATE OF FINAL RULE]. For claims filed before [EFFECTIVE DATE OF FINAL RULE], the rules in §404.1527 apply.

(a) General. As part of our consideration of all evidence in your claim under §404.1520b, we consider and articulate how we consider medical opinions and prior administrative medical findings under this section. We will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources. When a medical source provides one or more medical opinions or prior administrative medical findings, we will consider those medical opinions or prior administrative medical findings from that medical source together using the factors listed in paragraphs (c)(1) through (7) of this section, as appropriate. The most important factors we consider when we evaluate the evidentiary value of medical opinions and prior administrative medical findings are supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section). We will articulate how we considered the medical opinions and prior administrative medical findings in your claim according to paragraph (b) of this section.

(b) Articulation procedure. We will articulate in our determination or decision how persuasive we find the medical opinions and prior administrative medical findings in your case record as follows:

(1) Source-level articulation. Because many claims have voluminous case records containing many types of evidence from different sources, it is not administratively feasible for us to articulate in each determination or decision how we considered all of the factors for all of the medical opinions and prior administrative medical findings in your case record. Instead, when a medical source provides one or more medical opinion(s) or prior administrative medical finding(s), we will consider the medical opinion(s) or prior administrative medical finding(s) from that medical source together using the factors listed in paragraphs (c)(1) through (7) of this section, as appropriate. We are not required to articulate separately how we considered multiple medical opinions or prior administrative medical findings from one medical source.

(2) Most important factors. For medical opinions and prior administrative medical findings in your case record made by acceptable medical sources, we will explain how we considered the factors of supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section) in your determination or decision because those are the most important factors. We may, but are not required to, explain how we considered the factors in paragraphs (c)(3) through (7) of this section, as appropriate, when we articulate how we consider the medical opinions and prior administrative medical findings from acceptable medical sources in your case record.

(3) Equally persuasive medical opinions or prior administrative medical findings about the same issue from acceptable medical sources. When we find that two or more acceptable medical sources' medical opinions or prior administrative medical findings about the same issue are both equally well-supported (paragraph (c)(1) of this section) and consistent with the record (paragraph (c)(2) of this section) but are not exactly the

same, we will articulate how we considered the other most persuasive factors in paragraphs (c)(3) through (7) of this section for those medical opinions or prior administrative medical findings in your determination or decision.

(4) Medical opinions from medical sources who are not acceptable medical sources. We will articulate in your determination or decision how we considered the medical opinion(s) from a medical source who is not an acceptable medical source only if we find it to be well-supported and consistent with the record, as well as more valuable and persuasive than the medical opinion(s) and prior administrative medical findings from all of the acceptable medical sources in your case record. When we do articulate how we considered the medical opinion(s) of a medical source who is not an acceptable medical source, we will articulate in your determination or decision how we considered the factors of supportability (paragraph (c)(1) of this section), consistency (paragraph (c)(2) of this section), and the other most persuasive factors in paragraphs (c)(3) through (7) of this section, as applicable.

(c) Factors for consideration. 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).

(3) Relationship with the claimant— (i) Examining relationship. A medical source may have a better understanding of your impairment(s) if he or she examines you than if the medical source only reviews evidence in your folder.

(ii) Length of the treatment relationship. The length of time of the treatment relationship may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(iii) Frequency of examinations. The frequency of your visits with the medical source may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(iv) Purpose of treatment relationship. The purpose for treatment you received from the medical source may help demonstrate the level of knowledge the medical source has of your impairment(s).

(v) Extent of the treatment relationship. The kinds and extent of examinations and testing the medical source has performed or ordered from specialists or independent laboratories may help demonstrate the level of knowledge the medical source has of your impairment(s).

(4) Specialization. The medical opinion or prior administrative medical finding of a medical source who has received advanced education and training to become a specialist may be more persuasive about medical issues related to his or her area of specialty than the medical opinion or prior administrative medical finding of a medical source who is not a specialist.

(5) Familiarity with the entire record. The medical opinion or prior administrative medical finding of a medical source may be more persuasive if the evidence demonstrates that the medical source is familiar with the other evidence in your case record than if the medical source is not familiar with the other evidence in your case record.

(6) Understanding of our policy. The medical opinion or prior administrative medical finding of a medical source may be more persuasive if the evidence demonstrates that the medical source understands our disability programs and evidentiary requirements.

(7) Other factors. We will also consider any factors that tend to support or contradict a medical opinion or prior administrative medical finding.

20. Revise § 404.1521 to read as follows:

§ 404.1521 Establishing that you have a medically determinable impairment(s).

If you are not doing substantial gainful activity, we will then determine whether you have a medically determinable physical or mental impairment(s) (see §404.1520(a)(4)(ii)). Your impairment(s) must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Therefore, a physical or mental impairment must be established by objective medical evidence from an acceptable medical source. We will not use your statement of symptoms, a diagnosis, or a medical opinion to establish the existence of an impairment(s). After we establish that you have a medically determinable impairment(s), then we determine whether your impairment(s) is severe.

21. Revise § 404.1522 to read as follows:

§ 404.1522 What we mean by an impairment(s) that is not severe.

(a) Non-severe impairment(s). An impairment or combination of impairments is not severe if it does not significantly limit your physical or mental ability to do basic work activities.

(b) Basic work activities. When we talk about basic work activities, we mean the abilities and aptitudes necessary to do most jobs. Examples of these include—

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting.

22. Revise § 404.1523 to read as follows:

§ 404.1523 Multiple impairments.

(a) Unrelated severe impairments. We cannot combine two or more unrelated severe impairments to meet the 12-month duration test. If you have a severe impairment(s) and then develop another unrelated severe impairment(s) but neither one is expected to last for 12 months, we cannot find you disabled, even though the two impairments in combination last for 12 months.

(b) Concurrent impairments. If you have two or more concurrent impairments that, when considered in combination, are severe, we must determine whether the combined effect of your impairments can be expected to continue to be severe for 12 months. If one or more of your impairments improves or is expected to improve within 12 months, so that the combined effect of your remaining impairments is no longer severe, we will find that you do not meet the 12-month duration test.

(c) Combined effect. In determining whether your physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under the law, we will consider the combined effect of all of your impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity. If we do find a medically severe combination of impairments, we will consider the combined impact of the impairments throughout the disability determination process. If we do not find that you have a medically severe combination of impairments, we will determine that you are not disabled (see §404.1520).

23. In § 404.1525, revise the last sentence in paragraph (c)(2) to read as follows:

§ 404.1525 Listing of Impairments in appendix 1.

* * * * *

(c) * * *

(2) * * * Even if we do not include specific criteria for establishing a diagnosis or confirming the existence of your impairment, you must still show that you have a severe medically determinable impairment(s), as defined in §404.1521.

* * * * *

24. In § 404.1526, revise paragraphs (d) and (e) to read as follows:

§ 404.1526 Medical equivalence.

* * * * *

(d) Who is a designated medical or psychological consultant? A medical or psychological consultant designated by the Commissioner includes any medical or psychological consultant employed or engaged to make medical judgments by the Social Security Administration, the Railroad Retirement Board, or a State agency authorized to make disability determinations. See §404.1616 of this part for the necessary qualifications for medical consultants and psychological consultants and the limitations on what medical consultants who are not physicians can evaluate.

(e) Who is responsible for determining medical equivalence? (1) In cases where the State agency or other designee of the Commissioner makes the initial or reconsideration disability determination, a State agency medical or psychological consultant or other designee of the Commissioner (see §404.1616 of this part) has the overall responsibility for determining medical equivalence.

(2) For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining medical equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsideration determination is changed under §404.918 of this part, with the Associate Commissioner for Disability Policy or his or her delegate.

(3) For cases at the administrative law judge or Appeals Council level, the responsibility for deciding medical equivalence rests with the administrative law judge or Appeals Council.

25. Revise § 404.1527 to read as follows:

§ 404.1527 Evaluating opinion evidence.

This section applies to claims filed (see §404.614) before [EFFECTIVE DATE OF FINAL RULE]. For claims filed on or after [EFFECTIVE DATE OF FINAL RULE], the rules in §404.1520c apply.

(a) Definitions—(1) Medical opinions. Medical opinions are statements from acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(2) Treating source. Treating source means your own acceptable medical source who provides you, or has provided you, with medical treatment or evaluation and who has, or has had, an ongoing treatment relationship with you. Generally, we will consider that you have an ongoing treatment relationship with an acceptable medical source when the medical evidence establishes that you see, or have seen, the source with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for your medical condition(s). We may consider an acceptable medical source who has treated or evaluated you only a few times or only after long intervals (e.g., twice a year) to be your treating source if the nature and frequency of the treatment or evaluation is typical for your condition(s). We will not consider an acceptable medical

source to be your treating source if your relationship with the source is not based on your medical need for treatment or evaluation, but solely on your need to obtain a report in support of your claim for disability. In such a case, we will consider the acceptable medical source to be a nontreating source.

(b) How we consider medical opinions. In determining whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive. See §404.1520b.

(c) How we weigh medical opinions. Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (c)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) Examining relationship. Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) Treatment relationship. Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) 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 examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors

listed in paragraphs (c)(2)(i) and (ii) of this section, as well as the factors in paragraphs (c)(3) through (6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

(i) Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(ii) Nature and extent of the treatment relationship. Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) Supportability. The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight

we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) Consistency. Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) Specialization. We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) Other factors. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(d) Medical source opinions on issues reserved to the Commissioner. Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(2) of this section, but are, instead, opinions on issues reserved to the

Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) Opinions that you are disabled. We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled.

(2) Other opinions on issues reserved to the Commissioner. We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to this subpart, your residual functional capacity (see §§404.1545 and 404.1546), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (d)(1) and (d)(2) of this section.

(e) Evidence from our Federal or State agency medical or psychological consultants. The rules in §404.1513a apply except that when an administrative law judge gives controlling weight to a treating source's medical opinion, the administrative law judge is not required to explain in the decision the weight he or she gave to the prior administrative medical findings in the claim.

§ 404.1528. [Removed and Reserved]

26. Remove and reserve § 404.1528.

27. In § 404.1529, revise paragraph (a), the second and third sentences of paragraph (c)(1), paragraph (c)(3) introductory text, and the third sentence of paragraph (c)(4) to read as follows:

§ 404.1529 How we evaluate symptoms, including pain.

(a) General. In determining whether you are disabled, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence. We will consider all of your statements about your symptoms, such as pain, and any description your medical sources or nonmedical sources may provide about how the symptoms affect your activities of daily living and your ability to work. However, statements about your pain or other symptoms will not alone establish that you are disabled. There must be objective medical evidence from an acceptable medical source that shows you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and that, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings, and statements about how your symptoms affect you. We will then determine the extent to

which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work.

* * * * *

(c) * * *

(1) * * * In evaluating the intensity and persistence of your symptoms, we consider all of the available evidence from your medical sources and nonmedical sources about how your symptoms affect you. We also consider the medical opinions as explained in §404.1520c. * * *

* * * * *

(3) Consideration of other evidence. Because symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. The information that your medical sources or nonmedical sources provide about your pain or other symptoms (e.g., what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions that your medical sources or nonmedical sources report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented,

including information about your prior work record, your statements about your symptoms, evidence submitted by your medical sources, and observations by our employees and other persons. Section 404.1520c explains in detail how we consider medical opinions and prior administrative medical findings about the nature and severity of your impairment(s) and any related symptoms, such as pain. Factors relevant to your symptoms, such as pain, which we will consider include:

* * * * *

(4) * * * We will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between your statements and the rest of the evidence, including your history, the signs and laboratory findings, and statements by your medical sources or other persons about how your symptoms affect you. * * *

* * * * *

28. In § 404.1530, revise paragraph (a) to read as follows:

§ 404.1530 Need to follow prescribed treatment.

(a) What treatment you must follow. In order to get benefits, you must follow treatment prescribed by your medical source(s) if this treatment can restore your ability to work.

* * * * *

29. In § 404.1579, revise the second sentence of paragraph (b)(1) introductory text and the second sentence of paragraph (b)(4) to read as follows:

§ 404.1579 How we will determine whether your disability continues or ends.

* * * * *

(b) * * *

(1) * * * A determination that there has been a decrease in medical severity must be based on improvement in the symptoms, signs, and/or laboratory findings associated with your impairment(s). * * *

* * * * *

(4) * * * We will consider all evidence you submit and that we obtain from your medical sources and nonmedical sources. * * *

* * * * *

30. In § 404.1594, revise the second sentence of paragraph (b)(1) introductory text, the sixth sentence in Example 1 following paragraph (b)(1), the second sentence of paragraph (b)(6), and the fourth sentence of paragraph (c)(3)(v) to read as follows:

§ 404.1594 How we will determine whether your disability continues or ends.

* * * * *

(b) * * *

(1) * * * A determination that there has been a decrease in medical severity must be based on improvement in the symptoms, signs, and/or laboratory findings associated with your impairment(s).

Example 1: * * * When we reviewed your claim, your medical source, who has treated you, reported that he or she had seen you regularly every 2 to 3 months for the past 2 years. * * *

* * * * *

(6) * * * We will consider all evidence you submit and that we obtain from your medical sources and nonmedical sources. * * *

* * * * *

(c) * * *

(3) * * *

(v) * * * If you are able to engage in substantial gainful activity, we will determine whether an attempt should be made to reconstruct those portions of the missing file that were relevant to our most recent favorable medical decision (e.g., work history, medical evidence, and the results of consultative examinations). * * *

* * * * *

31. Amend appendix 1 to subpart P as follows:

a. In Part A:

i. Revise the second, third, and fourth sentences of 2.00.B.1.a;

ii. Revise 2.00.B.1.b;

iii. Revise the fourth sentence of 7.00H;

iv. Revise the second sentence of 8.00.C.3;

v. Revise the second sentence of 12.00.D.1.a;

vi. Revise the second sentence of 12.00.D.7; and

vii. Revise the forth sentence of 14.00H.

b. In Part B:

i. Revise the second, third, and fourth sentences of 102.00.B.1.a;

ii. Revise 102.00.B.1.b;

iii. Revise the second sentence of 108.00.C.3.;

iv. Revise the first sentence 108.00.E.3.a; and

v. Revise the second sentence of 112.00.D.1.

The revisions read as follows:

Appendix 1 to Subpart P of Part 404—

* * * * *

2.00 * * *

B. * * *

1. * * *

a. * * * We generally require both an otologic examination and audiometric testing to establish that you have a medically determinable impairment that causes your hearing loss. You should have this audiometric testing within 2 months of the otologic examination. Once we have evidence that you have a medically determinable impairment, we can use the results of later audiometric testing to assess the severity of your hearing loss without another otologic examination. * * *

b. The otologic examination must be performed by a licensed physician (medical or osteopathic doctor) or audiologist. It must include your medical history, your description of how your hearing loss affects you, and the physician's or audiologist's description of the appearance of the external ears (pinnae and external ear canals), evaluation of the tympanic membranes, and assessment of any middle ear abnormalities.

* * * * *

7.00 * * *

H. * * * (See sections 404.1521, 404.1529, 416.921, and 416.929 of this chapter.)

* * *

* * * * *

8.00 * * *

C. * * *

3. * * * We assess the impact of symptoms as explained in §§404.1521, 404.1529, 416.921, and 416.929 of this chapter. * * *

* * * * *

12.00 * * *

D. * * *

1. * * *

a. * * * See §§404.1521 and 416.921. * * *

* * * * *

7. * * * Such test results may be useful for disability evaluation when corroborated by other evidence from medical and nonmedical sources, including results from other psychological tests and information obtained in the course of the clinical evaluation. * * *

* * * * *

14.00 * * *

H. * * * See §§404.1521, 404.1529, 416.921, and 416.929. * * *

* * * * *

102.00 * * *

B. * * *

1. * * *

a. * * * We generally require both an otologic examination and audiometric testing to establish that you have a medically determinable impairment that causes your hearing loss. You should have this audiometric testing within 2 months of the otologic examination. Once we have evidence that you have a medically determinable impairment, we can use the results of later audiometric testing to assess the severity of your hearing loss without another otologic examination. * * *

b. The otologic examination must be performed by a licensed physician (medical or osteopathic doctor) or audiologist. It must include your medical history, your description of how your hearing loss affects you, and the physician's or audiologist's description of the appearance of the external ears (pinnae and external ear canals), evaluation of the tympanic membranes, and assessment of any middle ear abnormalities.

* * * * *

108.00. * * *

C. * * *

3. * * * We assess the impact of symptoms as explained in §§404.1521, 404.1529, 416.921, and 416.929 of this chapter.

* * * * *

E. * * *

3. * * *

a. General. We need documentation from an acceptable medical source to establish that you have a medically determinable impairment.* * *

* * * * *

112.00 * * *

D. * * *

1. * * * See §§404.1521 and 416.921. * * *

* * * * *

Subpart Q—Determinations of Disability

32. The authority citation for subpart Q of part 404 continues to read as follows:

Authority: Secs. 205(a), 221, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 421, and 902(a)(5)).

§ 404.1615 [Amended]

33. In§ 404.1615, remove paragraph (d) and redesignate paragraphs (e) through (g) as paragraphs (d) through (f).

34. Revise § 404.1616 to read as follows:

§ 404.1616 Medical consultants and psychological consultants.

(a) What is a medical consultant? A medical consultant is a licensed physician (see §404.1502(a)(1)) who is a member of a team that makes disability determinations in a State agency (see §404.1615), or who is a member of a team that makes disability determinations for us when we make disability determinations ourselves. The medical consultant completes the medical portion of the case review and any applicable residual functional capacity assessment about all physical impairment(s) in a claim.

(b) What is a psychological consultant? A psychological consultant is a licensed psychiatrist or psychologist (see §404.1502(a)(2)) who is a member of a team that makes disability determinations in a State agency (see §404.1615), or who is a member of a team that makes disability determinations for us when we make disability determinations ourselves. The psychological consultant completes the medical portion of the case review and any applicable residual functional capacity assessment about all mental impairment(s) in a claim. When we are unable to obtain the services of a qualified psychiatrist or psychologist despite making every reasonable effort in a claim involving a mental impairment(s), a medical consultant who is not a psychiatrist will evaluate the mental impairment(s).

(c) Cases involving both physical and mental impairments. In a case where there is evidence of both physical and mental impairments, the medical consultant will evaluate the physical impairments in accordance with paragraph (a) of this section, and the psychological consultant will evaluate the mental impairment(s) in accordance with paragraph (b) of this section.

35. Revise § 404.1617 to read as follows:

§ 404.1617 Reasonable efforts to obtain review by a physician, psychiatrist, and psychologist.

When the evidence of record indicates the existence of a physical impairment, the State agency must make every reasonable effort to ensure that a medical consultant completes the medical portion of the case review and any applicable residual functional capacity assessment. When the evidence of record indicates the existence of a mental

impairment, the State agency must make every reasonable effort to ensure that a psychological consultant completes the medical portion of the case review and any applicable residual functional capacity assessment. The State agency must determine if additional physicians, psychiatrists, and psychologists are needed to make the necessary reviews. When it does not have sufficient resources to make the necessary reviews, the State agency must attempt to obtain the resources needed. If the State agency is unable to obtain additional physicians, psychiatrists, and psychologists because of low salary rates or fee schedules, it should attempt to raise the State agency's levels of compensation to meet the prevailing rates for these services. If these efforts are unsuccessful, the State agency will seek assistance from us. We will assist the State agency as necessary. We will also monitor the State agency's efforts and where the State agency is unable to obtain the necessary services, we will make every reasonable effort to provide the services using Federal resources.

PART 416-SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

Subpart I—Determining Disability and Blindness

36. The authority citation for subpart I of part 416 continues to read as follows:

Authority: Secs. 221(m), 702(a)(5), 1611, 1614, 1619, 1631(a), (c), (d)(1), and (p), and 1633 of the Social Security Act (42 U.S.C. 421(m), 902(a)(5), 1382, 1382c, 1382h, 1383(a), (c), (d)(1), and (p), and 1383b); secs. 4(c) and 5, 6(c)–(e), 14(a), and 15,

Pub. L. 98–460, 98 Stat. 1794, 1801, 1802, and 1808 (42 U.S.C. 421 note, 423 note, and 1382h note).

37. Revise § 416.902 to read as follows:

§ 416.902 Definitions for this subpart.

As used in the subpart—

(a) Acceptable medical source means a medical source who is a:

(1) Licensed physician (medical or osteopathic doctor);

(2) Licensed psychologist, which includes:

(i) A licensed or certified psychologist at the independent practice level; or

(ii) A licensed or certified school psychologist, or other licensed or certified individual with another title who performs the same function as a school psychologist in a school setting, for impairments of intellectual disability, learning disabilities, and borderline intellectual functioning only;

(3) Licensed optometrist for impairments of visual disorders only (except, in Puerto Rico, for the measurement of visual acuity and visual fields only);

(4) Licensed podiatrist for impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle;

(5) Qualified speech-language pathologist for speech or language impairments only. For this source, qualified means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of

Clinical Competence in Speech-Language Pathology from the American Speech-Language-Hearing Association;

(6) Licensed audiologist for impairments of hearing loss and auditory processing disorders only (only in claims filed (see §416.325) on or after [EFFECTIVE DATE OF FINAL RULE]); or

(7) Licensed Advanced Practice Registered Nurse or other licensed advanced practice nurse with another title for impairments within his or her licensed scope of practice (only in claims filed (see §416.325) on or after [EFFECTIVE DATE OF FINAL RULE]).

(b) Adult means a person who is age 18 or older.

(c) Child means a person who has not attained age 18.

(d) Commissioner means the Commissioner of Social Security or his or her authorized designee.

(e) Disability redetermination means a redetermination of your eligibility based on disability using the rules for new applicants appropriate to your age, except the rules pertaining to performance of substantial gainful activity. For individuals who are working and for whom a disability redetermination is required, we will apply the rules in §§416.260-416.269. In conducting a disability redetermination, we will not use the rules for determining whether disability continues set forth in §416.994 or §416.994a. (See §416.987.)

(f) Impairment(s) means a medically determinable physical or mental impairment or a combination of medically determinable physical or mental impairments.

(g) Laboratory findings means anatomical, physiological, or psychological phenomena that can be shown by the use of medically acceptable laboratory diagnostic techniques. Diagnostic techniques include chemical tests (such as blood tests), electrophysiological studies (such as electrocardiograms and electroencephalograms), medical imaging (such as X-rays), and psychological tests.

(h) Marked and severe functional limitations, when used as a phrase, means the standard of disability in the Social Security Act for children claiming SSI benefits based on disability. It is a level of severity that meets, medically equals, or functionally equals the listings. (See §§416.906, 416.924, and 416.926a.) The words "marked" and "severe" are also separate terms used throughout this subpart to describe measures of functional limitations; the term "marked" is also used in the listings. (See §§416.924 and 416.926a.) The meaning of the words "marked" and "severe" when used as part of the phrase marked and severe functional limitations is not the same as the meaning of the separate terms "marked" and "severe" used elsewhere in 20 CFR 404 and 416. (See §§416.924(c) and 416.926a(e).)

(i) Medical source means an individual who is licensed as a healthcare worker by a State and working within the scope of practice permitted under State or Federal law, or an individual who is certified by a State as a speech-language pathologist or a school psychologist and acting within the scope of practice permitted under State or Federal law.

(j) Nonmedical source means a source of evidence who is not a medical source. This includes, but is not limited to:

(1) You;

(2) Educational personnel (for example, school teachers, counselors, early intervention team members, developmental center workers, and daycare center workers);

(3) Public and private social welfare agency personnel; and

(4) Family members, caregivers, friends, neighbors, employers, and clergy.

(k) Objective medical evidence means signs, laboratory findings, or both.

(l) Signs means anatomical, physiological, or psychological abnormalities that can be observed, apart from your statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, e.g., abnormalities of behavior, mood, thought, memory, orientation, development, or perception and must also be shown by observable facts that can be medically described and evaluated.

(m) State agency means an agency of a State designated by that State to carry out the disability or blindness determination function.

(n) Symptoms means your own description of your physical or mental impairment.

(o) The listings means the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter. When we refer to an impairment(s) that "meets, medically equals, or functionally equals the listings," we mean that the impairment(s) meets or medically equals the severity of any listing in appendix 1 of subpart P of part 404 of this chapter, as explained in §§416.925 and 416.926, or that it functionally equals the severity of the listings, as explained in §416.926a.

(p) We or us means, as appropriate, either the Social Security Administration or the State agency making the disability or blindness determination.

(q) You or your means, as appropriate, the person who applies for benefits or for a period of disability, the person for whom an application is filed, or the person who is receiving benefits based on disability or blindness.

38. In § 416.903, remove paragraph (e), redesignate paragraph (f) as paragraph (e), and revise newly redesignated paragraph (e) to read as follows:

§ 416.903 Who makes disability and blindness determinations.

* * * * *

(e) Determinations for childhood impairments. In making a determination under title XVI with respect to the disability of a child, we will make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the child's impairment(s) evaluates the case of the child.

39. Revise § 416.904 to read as follows:

§ 416.904 Decisions by other governmental agencies and nongovernmental entities.

Other governmental agencies and nongovernmental entities-- such as the Department of Veterans Affairs, the Department of Defense, the Department of Labor, the Office of Personnel Management, State agencies, and private insurers-- make disability, blindness, employability, Medicaid, workers' compensation, and other benefits decisions for their own programs using their own rules. Because a decision by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits is based on its rules, it is not binding on us and is not our decision about whether you are disabled or blind under our rules. Therefore, in

claims filed (see §416.325) on or after [EFFECTIVE DATE OF FINAL RULE] we will not provide any analysis in our determination or decision about a decision made by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits. However, we will consider in our determination or decision relevant supporting evidence underlying the other governmental agency or nongovernmental entity's decision that we receive as evidence in your claim.

§ 416.908 [Removed and Reserved]

40. Remove and reserve § 416.908:

41. Revise § 416.912 to read as follows:

§ 416.912 Responsibility for evidence.

(a) Your responsibility—(1) General. In general, you have to prove to us that you are blind or disabled. You must inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled (see § 416.913). This duty is ongoing and requires you to disclose any additional related evidence about which you become aware. This duty applies at each level of the administrative review process, including the Appeals Council level if the evidence relates to the period on or before the date of the administrative law judge hearing decision. We will consider only impairment(s) you say you have or about which we receive evidence. When you submit evidence received from another source, you must submit that evidence in its entirety,

unless you previously submitted the same evidence to us or we instruct you otherwise. If we ask you, you must inform us about:

(i) Your medical source(s);

(ii) Your age;

(iii) Your education and training;

(iv) Your work experience;

(v) Your daily activities both before and after the date you say that you became disabled;

(vi) Your efforts to work; and

(vii) Any other factors showing how your impairment(s) affects your ability to work, or, if you are a child, your functioning. In §§416.960 through 416.969, we discuss in more detail the evidence we need when we consider vocational factors.

(2) Completeness. The evidence in your case record must be complete and detailed enough to allow us to make a determination or decision about whether you are disabled or blind. It must allow us to determine—

(i) The nature and severity of your impairment(s) for any period in question;

(ii) Whether the duration requirement described in §416.909 is met; and

(iii) Your residual functional capacity to do work-related physical and mental activities, when the evaluation steps described in § 416.920(e) or (f)(1) apply, or, if you are a child, how you typically function compared to children your age who do not have impairments.

(3) Statutory blindness. If you are applying for benefits on the basis of statutory blindness, we will require an examination by a physician skilled in diseases of the eye or by an optometrist, whichever you may select.

(b) Our responsibility—(1) Development. Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical reports from your own medical sources and entities that maintain your medical sources' evidence when you give us permission to request the reports.

(i) Every reasonable effort means that we will make an initial request for evidence from your medical source or entity that maintains your medical source's evidence, and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one follow-up request to obtain the medical evidence necessary to make a determination. The medical source or entity that maintains your medical source's evidence will have a minimum of 10 calendar days from the date of our follow-up request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case.

(ii) Complete medical history means the records of your medical source(s) covering at least the 12 months preceding the month in which you file your application. If you say that your disability began less than 12 months before you filed your application,

we will develop your complete medical history beginning with the month you say your disability began unless we have reason to believe your disability began earlier.

(2) Obtaining a consultative examination. We may ask you to attend one or more consultative examinations at our expense. See §§416.917 through 416.919t for the rules governing the consultative examination process. Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources. We may order a consultative examination while awaiting receipt of medical source evidence in some instances, such as when we know a source is not productive, is uncooperative, or is unable to provide certain tests or procedures. We will not evaluate this evidence until we have made every reasonable effort to obtain evidence from your medical sources.

(3) Other work. In order to determine under §416.920(g) that you are able to adjust to other work, we must provide evidence about the existence of work in the national economy that you can do (see §§416.960 through 416.969a), given your residual functional capacity (which we have already assessed, as described in §416.920(e)), age, education, and work experience.

42. Revise § 416.913 to read as follows:

§ 416.913 Categories of evidence.

(a) What we mean by evidence. Subject to the provisions of paragraph (b), evidence is anything you or anyone else submits to us or that we obtain that relates to your claim. We consider evidence under §§416.920b, 416.920c (or under §416.927 for claims filed (see §416.325) before [EFFECTIVE DATE OF FINAL RULE]). We

evaluate evidence we receive according to the rules pertaining to the relevant category of evidence. The categories of evidence are:

(1) Objective medical evidence. Objective medical evidence is medical signs, laboratory findings, or both, as defined in §416.902(k).

(2) Medical opinions. A medical opinion is a statement from a medical source about what you can still do despite your impairment(s) and whether you have one or more impairment-related limitations or restrictions in the abilities listed in paragraphs (a)(2)(i)(A)-(D) and (a)(2)(ii)(A)-(F) of this section. (For claims filed (see §416.325) before [EFFECTIVE DATE OF FINAL RULE]), see §416.927(a) for the definition of medical opinion.)

(i) Medical opinions in adult claims are about impairment-related limitations and restrictions in:

(A) Your ability to perform physical demands of work activities, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping, or crouching);

(B) Your ability to perform mental demands of work activities, such as understanding; remembering; maintaining concentration, persistence, and pace; carrying out instructions; and responding appropriately to supervision, co-workers, and work pressures in a work setting;

(C) Your ability to perform other demands of work, such as seeing, hearing, and using other senses; and

(D) Your ability to adapt to environmental conditions, such as temperature extremes and fumes.

(ii) Medical opinions in child claims are about impairment-related limitations and restrictions in your abilities in the six domains of functioning:

(A) Acquiring and using information (see §416.926a(g));

(B) Attending and completing tasks (see §416.926a(h));

(C) Interacting and relating with others (see §416.926a(i));

(D) Moving about and manipulating objects (see §416.926a(j));

(E) Caring for yourself (see §416.926a(k)); and

(F) Health and physical well-being (see §416.926a(l)).

(3) Other medical evidence. Other medical evidence is evidence from a medical source that is not objective medical evidence or a medical opinion, including judgments about the nature and severity of your impairments, your medical history, clinical findings, diagnosis, treatment prescribed with response, or prognosis. (For claims filed (see §416.325) before [EFFECTIVE DATE OF FINAL RULE]), other medical evidence does not include diagnosis, prognosis, and statements that reflect judgments about the nature and severity of your impairment(s)).

(4) Statements from nonmedical sources. A statement from a nonmedical source is a statement(s) made by nonmedical sources (including you) about your impairment(s), your restrictions, your daily activities, your efforts to work, or any other relevant statements the nonmedical source makes to medical sources during the course of your examination or treatment or that he or she makes to us during interviews, on applications, in reports or letters, and in testimony in our administrative proceedings.

(5) Prior administrative medical findings. 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 §416.1400) based on their review of the evidence in your case record, such as:

(i) The existence and severity of your impairment(s);

(ii) The existence and severity of your symptoms;

(iii) Statements about whether your impairment(s) meets or medically equals any listing in the Listing of Impairments in Part 404, Subpart P, Appendix 1;

(iv) If you are a child, statements about whether your impairment(s) functionally equals the listings in Part 404, Subpart P, Appendix 1;

(v) If you are an adult, your residual functional capacity;

(vi) Whether your impairment(s) meets the duration requirement; and

(vii) How failure to follow prescribed treatment (see §404.1530) and drug addiction and alcoholism (see §404.1535) relate to your claim.

(b) Exceptions for privileged communications. (1) The privileged communications listed in paragraphs (b)(1)(i) and (ii) of this section are not evidence, and we will neither consider nor provide any analysis about them in your determination or decision. This exception for privileged communications applies equally whether your representative is an attorney or non-attorney.

(i) Oral or written communications between you and your representative that are subject to the attorney-client privilege, unless you voluntarily disclose the communication to us.

(ii) Your representative's analysis of your claim, unless he or she voluntarily discloses it to us. This analysis means information that is subject to the attorney work product doctrine, but it does not include medical evidence, medical source opinions, or any other factual matter that we may consider in determining whether or not you are entitled to benefits (see paragraph (b)(2) of this section).

(2) The attorney-client privilege generally protects confidential communications between an attorney and his or her client that are related to providing or obtaining legal advice. The attorney work product doctrine generally protects an attorney's analysis, theories, mental impressions, and notes. In the context of your disability claim, neither the attorney-client privilege nor the attorney work product doctrine allow you to withhold factual information, medical source opinions, or other medical evidence that we may consider in determining whether or not you are entitled to benefits. For example, if you tell your representative about the medical sources you have seen, your representative cannot refuse to disclose the identity of those medical sources to us based on the attorney-client privilege. As another example, if your representative asks a medical source to complete an opinion form related to your impairment(s), symptoms, or limitations, your representative cannot withhold the completed opinion form from us based on the attorney work product doctrine. The attorney work product doctrine would not protect the source's opinions on the completed form, regardless of whether or not your representative used the form in his or her analysis of your claim or made handwritten notes on the face of the report.

43. Add § 416.913a to read as follows:

§ 416.913a Evidence from our Federal or State agency medical or psychological consultants.

The following paragraphs (a) through (c) apply to our Federal or State agency medical or psychological consultants that we consult in connection with administrative law judge hearings and Appeals Council reviews:

(a) In claims adjudicated by the State agency, a State agency medical or psychological consultant may make the determination of disability together with a State agency disability examiner or provide medical evidence to a State agency disability examiner when the disability examiner makes the initial or reconsideration determination alone (see §416.1015(c) of this part). The following rules apply:

(1) When a State agency medical or psychological consultant makes the determination together with a State agency disability examiner at the initial or reconsideration level of the administrative review process as provided in §416.1015(c)(1), he or she will consider the evidence in your case record and make administrative findings about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or medically equals the requirements for any impairment listed in appendix 1 to this subpart, and your residual functional capacity. These administrative medical findings are based on the evidence in your case but are not in themselves evidence at the level of the administrative review process at which they are made. See §416.913(a)(5).

(2) When a State agency disability examiner makes the initial determination alone as provided in §416.1015(c)(3), he or she may obtain medical evidence from a State

agency medical or psychological consultant about one or more of the medical issues listed in paragraph (a)(1) of this section. In these cases, the State agency disability examiner will consider the medical evidence of the State agency medical or psychological consultant under §§416.920b and 416.920c.

(3) When a State agency disability examiner makes a reconsideration determination alone as provided in §416.1015(c)(3), he or she will consider prior administrative medical findings made by a State agency medical or psychological consultant at the initial level of the administrative review process, and any medical evidence provided by such consultants at the initial and reconsideration levels, about one or more of the medical issues listed in paragraph (a)(1)(i) of this section under §§416.920b and 416.920c.

(b) Administrative law judges are responsible for reviewing the evidence and making administrative findings of fact and conclusions of law. They will consider prior administrative medical findings and medical evidence from our Federal or State agency medical or psychological consultants as follows:

(1) Administrative law judges are not required to adopt any prior administrative medical findings, but they must consider this evidence according to §§416.920b and 416.920c because our Federal or State agency medical or psychological consultants are highly qualified experts in Social Security disability evaluation.

(2) Administrative law judges may also ask for medical evidence from expert medical sources. Administrative law judges will consider this evidence under §§416.920b and 416.920c, as appropriate.

(c) When the Appeals Council makes a decision, it will consider prior administrative medical findings according to the same rules for considering prior administrative medical findings as administrative law judges follow under paragraph (b) of this section.

44. In§ 416.918, revise paragraph (c) to read as follows:

§ 416.918 If you do not appear at a consultative examination.

* * * * *

(c) Objections by your medical source(s). If any of your medical sources tell you that you should not take the examination or test, you should tell us at once. In many cases, we may be able to get the information we need in another way. Your medical source(s) may agree to another type of examination for the same purpose.

45. In § 416.919g, revise paragraph (a) to read as follows:

§ 416.919g Who we will select to perform a consultative examination.

(a) We will purchase a consultative examination only from a qualified medical source. The medical source may be your own medical source or another medical source. If you are a child, the medical source we choose may be a pediatrician.

* * * * *

46. Revise § 416.919h to read as follows:

§ 416.919h Your medical source.

When, in our judgment, your medical source is qualified, equipped, and willing to perform the additional examination or test(s) for the fee schedule payment, and generally furnishes complete and timely reports, your medical source will be the preferred source for the purchased examination or test(s).

47. Revise § 416.919i to read as follows:

§ 416.919i Other sources for consultative examinations.

We will use a different medical source than your medical source for a purchased examination or test in situations including, but not limited to, the following:

(a) Your medical source prefers not to perform such an examination or does not have the equipment to provide the specific data needed;

(b) There are conflicts or inconsistencies in your file that cannot be resolved by going back to your medical source;

(c) You prefer a source other than your medical source and have a good reason for your preference;

(d) We know from prior experience that your medical source may not be a productive source, such as when he or she has consistently failed to provide complete or timely reports; or

(e) Your medical source is not a qualified medical source as defined in §416.919g.

48. In § 416.919n, revise paragraph (c)(6) to read as follows:

§ 416.919n Informing the medical source of examination scheduling, report content, and signature requirements.

* * * * *

(c) * * *

(6) A medical opinion. Although we will ordinarily request a medical opinion as part of the consultative examination process, the absence of a medical opinion in a consultative examination report will not make the report incomplete. See §416.913(a)(3); and

* * * * *

49. In § 416.920a, revise the second sentence of paragraph (b)(1) to read as follows:

§ 416.920a Evaluation of mental impairments.

* * * * *

(b) * * *

(1) * * * See §416.921 for more information about what is needed to show a medically determinable impairment. * * *

* * * * *

50. Revise § 416.920b to read as follows:

§ 416.920b How we consider evidence.

After we review all of the evidence relevant to your claim, we make findings about what the evidence shows.

(a) Complete and consistent evidence. If all of the evidence we receive, including all medical opinion(s), is consistent and there is sufficient evidence for us to determine whether you are disabled, we will make our determination or decision based on that evidence.

(b) Incomplete or inconsistent evidence. In some situations, we may not be able to make our determination or decision because the evidence in your case record is insufficient or inconsistent. We consider evidence to be insufficient when it does not contain all the information we need to make our determination or decision. We consider evidence to be inconsistent when it conflicts with other evidence, contains an internal conflict, is ambiguous, or when the medical evidence does not appear to be based on medically acceptable clinical or laboratory diagnostic techniques. If the evidence in your case record is insufficient or inconsistent, we may need to take the additional actions in paragraphs (b)(1) through (4) of this section.

(1) If any of the evidence in your case record, including any medical opinion(s) and prior administrative medical findings, is inconsistent, we will consider the relevant evidence and see if we can determine whether you are disabled based on the evidence we have.

(2) If the evidence is consistent but we have insufficient evidence to determine whether you are disabled, or if after considering the evidence we determine we cannot reach a conclusion about whether you are disabled, we will determine the best way to resolve the inconsistency or insufficiency. The action(s) we take will depend on the nature of the inconsistency or insufficiency. We will try to resolve the inconsistency or insufficiency by taking any one or more of the actions listed in paragraphs (b)(2)(i)

through (iv) of this section. We might not take all of the actions listed below. We will consider any additional evidence we receive together with the evidence we already have.

(i) We may recontact your medical source. We may choose not to seek additional evidence or clarification from a medical source if we know from experience that the source either cannot or will not provide the necessary evidence. If we obtain medical evidence over the telephone, we will send the telephone report to the source for review, signature, and return;

(ii) We may request additional existing evidence;

(iii) We may ask you to undergo a consultative examination at our expense (see §§416.917 through 416.919t); or

(iv) We may ask you or others for more information.

(3) When there are inconsistencies in the evidence that we cannot resolve or when, despite efforts to obtain additional evidence, the evidence is insufficient to determine whether you are disabled, we will make a determination or decision based on the evidence we have.

(c) Evidence that is neither valuable nor persuasive. Paragraphs (c)(1) through (3) apply in claims filed (see §416.325) on or after [EFFECTIVE DATE OF FINAL RULE]. Because the evidence listed in paragraphs (c)(1) through (3) of this section is inherently neither valuable nor persuasive to the issue of whether you are disabled or blind under the Act, we will not provide any analysis about how we considered such evidence in our determination or decision, even under §416.920c:

(1) Decisions by other governmental agencies and nongovernmental entities. See §416.904.

(2) Disability examiner findings. Findings made by a State agency disability examiner made at a previous level of adjudication about a medical issue, vocational issue, or the ultimate determination about whether you are disabled.

(3) Statements on issues reserved to the Commissioner. The statements listed in paragraphs (c)(3)(i) through (viii) of this section would direct our determination or decision that you are or are not disabled or blind within the meaning of the Act, but we are responsible for making the determination or decision about whether you are disabled or blind:

(i) Statements that you are or are not disabled, blind, able to work, or able to perform regular or continuing work;

(ii) Statements about whether or not your impairment(s) meets the duration requirement (see §416.909);

(iii) Statements about whether or not your impairment(s) meets or medically equals any listing in the Listing of Impairments in 20 CFR Part 404, Subpart P, Appendix 1;

(iv) If you are a child, statements about whether or not your impairment(s) functionally equals the listings in appendix 1 to subpart P of part 404 (see §416.926a);

(v) If you are an adult, statements about what your residual functional capacity is using our programmatic terms about the functional exertional levels in appendix 2 to subpart P of part 404, Rule 200.00 instead of descriptions about your functional abilities and limitations (see §416.945);

(vi) If you are an adult, statements about whether or not your residual functional capacity prevents you from doing past relevant work (see §416.960);

(vii) If you are an adult, statements that you do or do not meet the requirements of a medical-vocational rule in appendix 2 to subpart P of part 404; and

(viii) Statements about whether or not your disability continues or ends when we conduct a continuing disability review (see §416.994).

51. Add § 416.920c to read as follows:

§ 416.920c How we consider and articulate medical opinions and prior administrative medical findings.

This section applies to claims filed (see §416.325) on or after [EFFECTIVE DATE OF FINAL RULE]. For claims filed before [EFFECTIVE DATE OF FINAL RULE], the rules in §416.927 apply.

(a) General. As part of our consideration of all evidence in your claim under §416.920b, we consider and articulate how we consider medical opinions and prior administrative medical findings under this section. We will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources. When a medical source provides one or more medical opinions or prior administrative medical findings, we will consider those medical opinions or prior administrative medical findings from that medical source together using the factors listed in paragraphs (c)(1) through (7) of this section, as appropriate. The most important factors we consider when we evaluate the evidentiary value of medical opinions and prior administrative medical findings are supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section). We will articulate how we considered the medical opinions and

prior administrative medical findings in your claim according to paragraph (b) of this section.

(b) Articulation procedure. We will articulate in our determination or decision how persuasive we find the medical opinions and prior administrative medical findings in your case record as follows:

(1) Source-level articulation. Because many claims have voluminous case records containing many types of evidence from different sources, it is not administratively feasible for us to articulate in each determination or decision how we considered all of the factors for all of the medical opinions and prior administrative medical findings in your case record. Instead, when a medical source provides one or more medical opinion(s) or prior administrative medical finding(s), we will consider the medical opinion(s) or prior administrative medical finding(s) from that medical source together using the factors listed in paragraphs (c)(1) through (7) of this section, as appropriate. We are not required to articulate separately how we considered multiple medical opinions or prior administrative medical findings from one medical source.

(2) Most important factors. For medical opinions and prior administrative medical findings in your case record made by acceptable medical sources, we will explain how we considered the factors of supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section) in your determination or decision because those are the most important factors. We may, but are not required to, explain how we considered the factors in paragraphs (c)(3) through (7) of this section, as appropriate, when we articulate how we consider the medical opinions and prior administrative medical findings from acceptable medical sources in your case record.

(3) Equally persuasive medical opinions or prior administrative medical findings about the same issue from acceptable medical sources. When we find that two or more acceptable medical sources' medical opinions or prior administrative medical findings about the same issue are both equally well-supported (paragraph (c)(1) of this section) and consistent with the record (paragraph (c)(2) of this section) but are not exactly the same, we will articulate how we considered the other most persuasive factors in paragraphs (c)(3) through (7) of this section for those medical opinions or prior administrative medical findings in your determination or decision.

(4) Medical opinions from medical sources who are not acceptable medical sources. We will articulate in your determination or decision how we considered the medical opinion(s) from a medical source who is not an acceptable medical source only if we find it to be well-supported and consistent with the record, as well as more valuable and persuasive than the medical opinion(s) and prior administrative medical findings from all of the acceptable medical sources in your case record. When we do articulate how we considered the medical opinion(s) of a medical source who is not an acceptable medical source, we will articulate in your determination or decision how we considered the factors of supportability (paragraph (c)(1) of this section), consistency (paragraph (c)(2) of this section), and the other most persuasive factors in paragraphs (c)(3) through (7) of this section, as applicable.

(c) Factors for consideration. 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).

(3) Relationship with the claimant— (i) Examining relationship. A medical source may have a better understanding of your impairment(s) if he or she examines you than if the medical source only reviews evidence in your folder.

(ii) Length of the treatment relationship. The length of time of the treatment relationship may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(iii) Frequency of examinations. The frequency of your visits with the medical source may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(iv) Purpose of treatment relationship. The purpose for treatment you received from the medical source may help demonstrate the level of knowledge the medical source has of your impairment(s).

(v) Extent of the treatment relationship. The kinds and extent of examinations and testing the medical source has performed or ordered from specialists or independent laboratories may help demonstrate the level of knowledge the medical source has of your impairment(s).

(4) Specialization. The medical opinion or prior administrative medical finding of a medical source who has received advanced education and training to become a specialist may be more persuasive about medical issues related to his or her area of specialty than the medical opinion or prior administrative medical finding of a medical source who is not a specialist.

(5) Familiarity with the entire record. The medical opinion or prior administrative medical finding of a medical source may be more persuasive if the evidence demonstrates that the medical source is familiar with the other evidence in your case record than if the medical source is not familiar with the other evidence in your case record.

(6) Understanding of our policy. The medical opinion or prior administrative medical finding of a medical source may be more persuasive if the evidence demonstrates that the medical source understands our disability programs and evidentiary requirements.

(7) Other factors. We will also consider any factors that tend to support or contradict a medical opinion or prior administrative medical finding.

52. Revise § 416.921 to read as follows:

§ 416.921 Establishing that you have a medically determinable impairment(s).

If you are not doing substantial gainful activity, we will then determine whether you have a medically determinable physical or mental impairment(s) (see §416.920(a)(4)(ii)). Your impairment(s) must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Therefore, a physical or mental impairment must be

established by objective medical evidence from an acceptable medical source. We will not use your statement of symptoms, a diagnosis, or a medical opinion to establish the existence of an impairment(s). After we establish that you have a medically determinable impairment(s), then we determine whether your impairment(s) is severe.

53. Revise § 416.922 to read as follows:

§ 416.922 What we mean by an impairment(s) that is not severe in an adult.

(a) Non-severe impairment(s). An impairment or combination of impairments is not severe if it does not significantly limit your physical or mental ability to do basic work activities.

(b) Basic work activities. When we talk about basic work activities, we mean the abilities and aptitudes necessary to do most jobs. Examples of these include—

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting.

54. Revise § 416.923 to read as follows:

§ 416.923 Multiple impairments.

(a) Unrelated severe impairments. We cannot combine two or more unrelated severe impairments to meet the 12-month duration test. If you have a severe impairment(s) and then develop another unrelated severe impairment(s) but neither one is expected to last for 12 months, we cannot find you disabled, even though the two impairments in combination last for 12 months.

(b) Concurrent impairments. If you have two or more concurrent impairments that, when considered in combination, are severe, we must determine whether the combined effect of your impairments can be expected to continue to be severe for 12 months. If one or more of your impairments improves or is expected to improve within 12 months, so that the combined effect of your remaining impairments is no longer severe, we will find that you do not meet the 12-month duration test.

(c) Combined effect. In determining whether your physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under the law, we will consider the combined effect of all of your impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity. If we do find a medically severe combination of impairments, we will consider the combined impact of the impairments throughout the disability determination process. If we do not find that you have a medically severe combination of impairments, we will determine that you are not disabled (see §§416.920 and 416.924).

55. In § 416.924a, revise paragraph (a) introductory text, the last sentence of paragraph (a)(1)(i), the last sentence in paragraph (a)(1)(iii), and the paragraph (a)(2) heading to read as follows:

§ 416.924a Considerations in determining disability for children.

(a) Basic considerations. We consider all evidence in your case record (see §416.913). The evidence in your case record may include information from medical sources (such as your pediatrician or other physician; psychologist; qualified speech-language pathologist; and physical, occupational, and rehabilitation therapists) and nonmedical sources (such as your parents, teachers, and other people who know you).

(1) * * *

(i) * * * (See §416.920c.)

* * * * *

(iii) * * * When a medical source has accepted and relied on such information to reach a diagnosis, we may consider this information to be a sign, as defined in §416.902(l).

(2) Statements from nonmedical sources. * * *

* * * * *

56. In § 416.924b, revise the first sentence of paragraph (b)(3) to read as follows:

§ 416.924b Age as a factor of evaluation in the sequential evaluation process for children.

* * * * *

(b) * * *

(3) Notwithstanding the provisions in paragraph (b)(1) of this section, we will not compute a corrected chronological age if the medical evidence shows that your medical source has already considered your prematurity in his or her assessment of your development. * * *

57. In § 416.925, revise the last sentence in paragraph (c)(2) to read as follows:

§ 416.925 Listing of Impairments in appendix 1.

* * * * *

(c) * * *

(2) * * * Even if we do not include specific criteria for establishing a diagnosis or confirming the existence of your impairment, you must still show that you have a severe medically determinable impairment(s), as defined in §§416.921 and 416.924(c).

* * * * *

58. In § 416.926, revise paragraphs (d) and (e) to read as follows:

§ 416.926 Medical equivalence for adults and children.

* * * * *

(d) Who is a designated medical or psychological consultant? A medical or psychological consultant designated by the Commissioner includes any medical or psychological consultant employed or engaged to make medical judgments by the Social Security Administration, the Railroad Retirement Board, or a State agency authorized to make disability determinations. See §416.1016 of this part for the necessary

qualifications for medical consultants and psychological consultants and the limitations on what medical consultants who are not physicians can evaluate.

(e) Who is responsible for determining medical equivalence? (1) In cases where the State agency or other designee of the Commissioner makes the initial or reconsideration disability determination, a State agency medical or psychological consultant or other designee of the Commissioner (see §416.1016 of this part) has the overall responsibility for determining medical equivalence.

(2) For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining medical equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsideration determination is changed under §416.1418 of this part, with the Associate Commissioner for Disability Policy or his or her delegate.

(3) For cases at the administrative law judge or Appeals Council level, the responsibility for deciding medical equivalence rests with the administrative law judge or Appeals Council.

59. In § 416.926a, revise the second sentence of paragraph (b)(3) to read as follows:

§ 416.926a Functional equivalence for children.

* * * * *

(b) * * *

(3) * * * We will ask for information from your medical sources who can give us medical evidence, including medical opinions, about your limitations and restrictions. * * *

* * * * *

60. Revise § 416.927 to read as follows:

§ 416.927 Evaluating opinion evidence.

This section applies to claims filed (see §416.325) before [EFFECTIVE DATE OF FINAL RULE]. For claims filed on or after [EFFECTIVE DATE OF FINAL RULE], the rules in §416.920c apply.

(a) Definitions—(1) Medical opinions. Medical opinions are statements from acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(2) Treating source. Treating source means your own acceptable medical source who provides you, or has provided you, with medical treatment or evaluation and who has, or has had, an ongoing treatment relationship with you. Generally, we will consider that you have an ongoing treatment relationship with an acceptable medical source when the medical evidence establishes that you see, or have seen, the source with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for your medical condition(s). We may consider an acceptable medical source who has treated or evaluated you only a few times or only after long intervals (e.g., twice a year) to be your treating source if the nature and frequency of the treatment or

evaluation is typical for your condition(s). We will not consider an acceptable medical source to be your treating source if your relationship with the source is not based on your medical need for treatment or evaluation, but solely on your need to obtain a report in support of your claim for disability. In such a case, we will consider the acceptable medical source to be a nontreating source.

(b) How we consider medical opinions. In determining whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive. See §416.920b.

(c) How we weigh medical opinions. Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (c)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) Examining relationship. Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) Treatment relationship. Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) 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 examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When

we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (ii) of this section, as well as the factors in paragraphs (c)(3) through (6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

(i) Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(ii) Nature and extent of the treatment relationship. Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) Supportability. The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) Consistency. Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) Specialization. We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) Other factors. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(d) Medical source opinions on issues reserved to the Commissioner. Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(2) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) Opinions that you are disabled. We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled.

(2) Other opinions on issues reserved to the Commissioner. We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to this subpart, your residual functional capacity (see §§416.945 and 416.946), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (d)(1) and (2) of this section.

(e) Evidence from our Federal or State agency medical or psychological consultants. The rules in §416.913a apply except that when an administrative law judge gives controlling weight to a treating source's medical opinion, the administrative law

judge is not required to explain in the decision the weight he or she gave to the prior administrative medical findings in the claim.

§ 416.928. [Removed and Reserved]

61. Remove and reserve § 416.928.

62. In § 416.929, revise paragraph (a), the second and third sentences of paragraph (c)(1), paragraph (c)(3) introductory text, and the third sentence of paragraph (c)(4) to read as follows:

§ 416.929 How we evaluate symptoms, including pain.

(a) General. In determining whether you are disabled, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence. We will consider all of your statements about your symptoms, such as pain, and any description your medical sources or nonmedical sources may provide about how the symptoms affect your activities of daily living and your ability to work (or, if you are a child, your functioning). However, statements about your pain or other symptoms will not alone establish that you are disabled. There must be objective medical evidence from an acceptable medical source that shows you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and that, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be accepted as

consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings, and statements about how your symptoms affect you. We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work (or if you are a child, your functioning).

* * * * *

(c) * * *

(1) * * * In evaluating the intensity and persistence of your symptoms, we consider all of the available evidence from your medical sources and nonmedical sources about how your symptoms affect you. We also consider the medical opinions as explained in §416.920c. * * *

* * * * *

(3) Consideration of other evidence. Because symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. The information that your medical sources or nonmedical sources provide about your pain or other symptoms (e.g., what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the intensity and persistence of your symptoms. Because symptoms, such as pain, are

subjective and difficult to quantify, any symptom-related functional limitations and restrictions that your medical sources or nonmedical sources report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your medical sources, and observations by our employees and other persons. If you are a child, we will also consider all of the evidence presented, including evidence submitted by your medical sources (such as physicians, psychologists, and therapists) and nonmedical sources (such as educational agencies and personnel, parents and other relatives, and social welfare agencies). Section 416.920c explains in detail how we consider medical opinions and prior administrative medical findings about the nature and severity of your impairment(s) and any related symptoms, such as pain. Factors relevant to your symptoms, such as pain, which we will consider include:

* * * * *

(4) * * * We will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between your statements and the rest of the evidence, including your history, the signs and laboratory findings, and statements by your medical sources or other persons about how your symptoms affect you. * * *

* * * * *

63. In § 416.930 ,revise paragraph (a) to read as follows:

§ 416.930 Need to follow prescribed treatment.

(a) What treatment you must follow. In order to get benefits, you must follow treatment prescribed by your medical source(s) if this treatment can restore your ability to work.

* * * * *

64. In § 416.993, revise the seventh and ninth sentences of paragraph (b) to read as follows:

§ 416.993 Medical evidence in continuing disability review cases.

* * * * *

(b) * * * See §416.912(b)(1)(i) concerning what we mean by every reasonable effort. * * * See §416.912(b)(1)(ii).

* * * * *

65. In § 416.994, revise the sixth sentence in Example 1 following paragraph (b)(1)(i), the second sentence of paragraph (b)(1)(vi), and the fourth sentence of (b)(2)(iv)(E) to read as follows:

§ 416.994 How we will determine whether your disability continues or ends.

* * * * *

(b) * * *

(1) * * *

(i) * * *

Example 1: * * * When we reviewed your claim your medical source who has treated you reported that he had seen you regularly every 2 to 3 months for the past 2 years. * * *

* * * * *

(vi) * * * We will consider all evidence you submit and that we obtain from your medical sources and nonmedical sources. * * *

* * * * *

(2) * * *

(iv) * * *

(E) * * * If you are able to engage in substantial gainful activity, we will determine whether an attempt should be made to reconstruct those portions of the missing file that were relevant to our most recent favorable medical decision (e.g., work history, medical evidence, and the results of consultative examinations). * * *

66. In§ 416.994a, revise the second sentence of paragraph (a)(2), the first sentence in paragraph (c)(2), the fourth sentence of paragraph (d), and paragraph (i)(1) introductory text to read as follows:

§ 416.994a How we will determine whether your disability continues or ends, and whether you are and have been receiving treatment that is medically necessary and available, disabled children.

(a) * * *

(2) * * * We will consider all evidence you submit and that we obtain from your medical and nonmedical sources. * * *

* * * * *

(c) * * *

(2) The terms symptoms, signs, and laboratory findings are defined in §416.902. * * *

(d) * * * If not, we will determine whether an attempt should be made to reconstruct those portions of the missing file that were relevant to our most recent favorable determination or decision (e.g., school records, medical evidence, and the results of consultative examinations). * * *

* * * * *

(i) * * *

(1) What we mean by treatment that is medically necessary. Treatment that is medically necessary means treatment that is expected to improve or restore your functioning and that was prescribed by your medical source. If you do not have a medical source, we will decide whether there is treatment that is medically necessary that could have been prescribed by a medical source. The treatment may include (but is not limited to)—

* * * * *

Subpart J—Determinations of Disability

67. The authority citation for subpart J of part 416 continues to read as follows:

Authority: Secs. 702(a)(5), 1614, 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1382c, 1383, and 1383b).

§ 416.1015 [Amended]

68. In § 416.1015, remove paragraph (d) and redesignate paragraphs (e) through (h) as paragraphs (d) through (g).

69. Revise § 416.1016 to read as follows:

§ 416.1016 Medical consultants and psychological consultants.

(a) What is a medical consultant? A medical consultant is a licensed physician (see §416.902(a)(1)) who is a member of a team that makes disability determinations in a State agency (see §416.915), or who is a member of a team that makes disability determinations for us when we make disability determinations ourselves. The medical consultant completes the medical portion of the case review and any applicable residual functional capacity assessment about all physical impairment(s) in a claim.

(b) What is a psychological consultant? A psychological consultant is a licensed psychiatrist or psychologist (see §416.902(a)(2)) who is a member of a team that makes disability determinations in a State agency (see §416.1015), or who is a member of a team that makes disability determinations for us when we make disability determinations ourselves. The psychological consultant completes the medical portion of the case review and any applicable residual functional capacity assessment about all mental impairment(s) in a claim. When we are unable to obtain the services of a qualified psychiatrist or psychologist despite making every reasonable effort in a claim involving a mental impairment(s), a medical consultant who is not a psychiatrist will evaluate the mental impairment(s).

(c) Cases involving both physical and mental impairments. In a case where there is evidence of both physical and mental impairments, the medical consultant will evaluate the physical impairments in accordance with paragraph (a) of this section, and the psychological consultant will evaluate the mental impairment(s) in accordance with paragraph (b) of this section.

70. Revise § 416.1017 to read as follows:

§ 416.1017 Reasonable efforts to obtain review by a physician, psychiatrist, and psychologist.

When the evidence of record indicates the existence of a physical impairment, the State agency must make every reasonable effort to ensure that a medical consultant completes the medical portion of the case review and any applicable residual functional capacity assessment. When the evidence of record indicates the existence of a mental impairment, the State agency must make every reasonable effort to ensure that a psychological consultant completes the medical portion of the case review and any applicable residual functional capacity assessment. The State agency must determine if additional physicians, psychiatrists, and psychologists are needed to make the necessary reviews. When it does not have sufficient resources to make the necessary reviews, the State agency must attempt to obtain the resources needed. If the State agency is unable to obtain additional physicians, psychiatrists, and psychologists because of low salary rates or fee schedules, it should attempt to raise the State agency's levels of compensation to meet the prevailing rates for these services. If these efforts are unsuccessful, the State agency will seek assistance from us. We will assist the State agency as necessary. We

will also monitor the State agency's efforts and where the State agency is unable to obtain the necessary services, we will make every reasonable effort to provide the services using Federal resources.

Subpart N—Determinations, Administrative Review Process, and Reopening of Determinations and Decisions

71. The authority for subpart N continues to read as follows:

Authority: Secs. 702(a)(5), 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1383, and 1383b); sec. 202, Pub. L. 108-203, 118 Stat. 509 (42 U.S.C. 902 note).

72. In § 416.1406, revise the fourth sentence of paragraph (b)(2) to read as follows:

§ 416.1406 Testing modifications to the disability determination procedures.

* * * * *

(b) * * *

(2) * * * However, before an initial determination is made in any case where there is evidence which indicates the existence of a mental impairment, the decisionmaker will make every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment pursuant to our existing procedures (see §416.1017). * * *

* * * * *

73. In § 416.1442, revise paragraph (f)(1) to read as follows:

§ 416.1442 Prehearing proceedings and decisions by attorney advisors.

* * * * *

(f) * * *

(1) Authorize an attorney advisor to exercise the functions performed by an administrative law judge under §§416.913a, 416.920a, 416.926, and 416.946.

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