

NATIONAL ORGANIZATION OF
SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES
(NOSSCR)

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Executive Director
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October 28, 2005

The Honorable Sander M. Levin, Ranking Member
Subcommittee on Social Security
Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Representative Levin:

This is in response to the questions in your letter of October 12, 2005, requesting additional information following the September 27, 2005, joint hearing before the Social Security and Human Resources Subcommittees on the Commissioner of Social Security's proposed improvements to the disability determination process.

1. Why would a claimant or a professional representative seek to postpone a hearing?
What factors are weighed in deciding whether to seek a postponement?

The primary reason that an unrepresented claimant would seek to postpone a hearing would be to obtain representation. Under SSA's own policies, before a waiver of the right to counsel is considered valid, the ALJ must both send a letter to the claimant in advance explaining that right and confirm on the record at the hearing that the ALJ again told the claimant about the right to counsel and determined that the claimant was competent to understand. HALLEX I-2-6-52A.¹ If the claimant wishes to obtain representation, the ALJ should postpone the hearing. *Id.*

We encourage our members to seek postponements as infrequently as possible because of the length of time claimants must wait for a hearing date and because of the potential disruption to the overall hearings process. However, there are circumstances when a postponement is necessary to adequately represent the claimant. One of the main reasons that a representative may seek a postponement of a scheduled hearing is when the claimant seeks and obtains representation shortly before the hearing or after receiving the hearing notice, frequently fewer

¹ "HALLEX" is the acronym for SSA's "Hearing, Appeals, and Litigation Law Manual." The HALLEX conveys guiding principles, procedural guidance and information to the Office of Hearings and Appeals (OHA) staff. It also defines procedures for carrying out policy and provides guidance for processing and adjudicating claims at the Hearing, Appeals Council and Civil Actions levels. HALLEX I-1-0-1. It is available online at: http://www.ssa.gov/OP_Home/hallex/hallex.html.

than 20 days before the hearing date.² Based on the experience of our members, this is not an uncommon occurrence since the ALJ hearing is the claimant's first in-person contact with an adjudicator (this would not change under the NPRM). It should be noted that the current regulations state that a good reason for requesting a postponement is when the representative is appointed within 30 days of the scheduled hearing date and needs additional time to prepare.³

Under this circumstance, whether a representative and claimant decide to proceed with the scheduled hearing or request a postponement will normally depend on the quality of the records already in the hearing record file. After representation is obtained, the representative will need time to review the file in order to formulate legal arguments and, most importantly, develop additional evidence. If further evidence is needed to fully develop the claim, which is typically the case, then additional time will be required to request and obtain the records and other information.

The other most frequent reason for requesting a hearing postponement is that the claimant is ill or hospitalized. SSA's regulations require the ALJ to reschedule the hearing in this circumstance.⁴

Other reasons for requesting a postponement include:

- Serious illness or death of a family member.
- Lack of transportation to the hearing site. This is a problem not only in urban areas where there is mass transportation but the claimant lacks funds to pay the fare, but also is a problem for claimants who reside in rural areas and small towns and must travel some distance to a hearing site.
- The claimant is homeless or is being evicted.
- The representative has a scheduling conflict.
- The claimant cannot be located.

SSA's regulations, 20 C.F.R. §§ 404.936 and 416.1436, provide a nonexhaustive list of reasons, including many listed above, for requesting that the hearing be rescheduled.

Factors considered by representatives in deciding whether to seek a postponement include:

- The length of time the claimant has waited for a hearing.
- The claimant's medical condition.
- The claimant's financial situation.
- Whether further development is needed.
- The impact on the system.
- What the client/claimant wishes to do.

Decisions will not necessarily depend on a single factor but will involve a discussion with the claimant. Ultimately, the decision rests with the client, after the benefits and risks have been explained.

² Under current regulations, only a 20-day notice is required. 20 C.F.R. §§ 404.938(a) and 416.1438(a).

³ 20 C.F.R. §§ 404.936(f)(2) and 416.1436(f)(2).

⁴ 20 C.F.R. §§ 404.936(e)(1) and 416.1436(e)(1).

2. In your experience, what are some of the reasons for delay in obtaining evidence? What are some of the obstacles encountered in developing a complete evidentiary record? Please describe the procedures your office and other NOSSCR members utilize in obtaining needed evidence.

Our office procedures are designed to efficiently order, procure and submit medical and other evidence which will result in favorable decisions for our clients at the earliest possible time. We employ staff who work full-time doing nothing but sending out requests, following up by phone call and fax, and reviewing responses for completeness. Nevertheless, like all representatives, we face numerous obstacles and lengthy delays in a significant number of cases. Based on our review of cases in which claimants tried to proceed without representation, the problems with developing a complete evidentiary record are even worse for the pro se claimants.

Problems with developing complete evidentiary files are many and varied, and include the following:

- Physicians who are understaffed, have copying and/or fax machines which are reportedly broken, and/or clearly do not see fulfilling record requests from attorneys as a high priority;
- Physicians who do not want to provide any records until a past-due bill for medical services is paid by the claimant;
- Physicians who will provide only their handwritten and marginally legible treatment notes, but will not take the time to write a letter or complete a form regarding their patients' impairments and functional limitations, regardless of whether a fee is offered for their services;
- Hospitals which have either closed or changed ownership, which often results in records being transferred to other sites with no notice to former patients;
- Hospitals which, for good reason, will not release records of inpatient hospitalizations until the attending physician signs the chart, which may take weeks or even months after discharge;
- Hospitals which cannot locate Emergency Room treatment records unless they are given a specific date of treatment, which claimants often cannot remember;
- Hospitals which insist on receiving their own form releases, even when a general HIPAA-compliant form has already been executed by the claimant;
- Mental health outpatient treatment centers which erroneously claim that HIPAA prohibits them from releasing psychotherapy notes;
- Claimants who, because of mental impairments, are unable to recall all of their treatment sources (e.g., a claimant with a hearing scheduled in early November who, despite repeated questioning, cannot remember what hospital he was psychiatrically admitted to for a period of several weeks);
- Claimants who have used different names in the past, making location of their records difficult if not impossible.

In addition to this nonexhaustive list of problems, it should be noted that virtually all providers expect pre-payment for copies of records. While some states have statutes which limit the charges that can be imposed by providers, many do not. Moreover, while private attorneys have the resources to advance costs for their clients, many legal services organizations do not, and

unrepresented claimants may withdraw their requests for records in the face of what are, for them, significant bills which they cannot afford to pay. Finally, although ALJs have the nominal power to issue subpoenas at 20 C.F.R. §§ 404.1450 and 416.950, they do not have the power to enforce subpoenas with which providers fail to voluntarily comply, and the United States Attorneys' offices which have such power do not have the resources to devote to such activities.

3. What can be done to improve the responsiveness and timeliness of those requested to provide medical and other evidence? How could we compel or persuade them to respond?

As discussed in the answer to question 2, there are many reasons for delays in obtaining medical evidence. Ways to improve the responsiveness and timeliness include:

- Provide adequate reimbursement rates to providers.
- Contact providers on a repeated basis. Medical providers, whether hospitals, clinics, physicians, or other sources, are extremely busy. We find that usually after three or four requests or calls, the provider will respond, but that requires allocation of personnel time by representatives and entails delay in submission of evidence.
- HIPAA has a 30-day response time requirement. However, many medical facilities are simply unable to comply. There is no penalty if they fail to comply.

Formal judicial proceedings have strict discovery rules and sanctions if they are violated. Similarly strict rules would be inappropriate in the disability claims process which is informal and nonadversarial. One tool that is available to a representative is requesting that an ALJ issue a subpoena for production of records. 20 C.F.R. §§ 404.950(d) and 416.1450(d). The request must be made at least 5 days before the hearing (the proposed rule would increase the time to 20 days before the hearing). While there is no effective way to enforce the subpoenas, our members report that providers frequently will respond to the records request once the subpoena is received. Even with a subpoena, additional follow-up contact with the provider will be needed. However, we do not ask for subpoenas in every case as we recognize the additional burden such a request places on ALJs and their offices.

4. Why might a claimant or professional representative present evidence at the hearing itself, rather than submitting it in advance?

At the hearing on September 27, 2005, ALJ Dana McDonald was asked whether there was much abuse of the system so far as late submission of evidence. He responded that there was no real abuse of the system. He noted that often evidence comes in shortly before the hearing and he recognized that representatives cannot request medical evidence on a frequent basis. We agree with ALJ McDonald.

The most frequent reason for presenting evidence at the hearing, rather than in advance, is that it is received shortly before the hearing. We find, and other members report, that OHAs have difficulty associating medical records with the claimant's file in a timely manner. If it is shortly before the hearing (e.g., 10 days), the representative will take the records to the hearing or hand-deliver them in advance. Even in the latter case, a duplicate set may be taken to the hearing.

Even where evidence has been sent well in advance of the hearing, representatives will take a duplicate copy to the hearing because, in their experience, the original records are misplaced at the hearings office and will not be in the file. Some ALJs routinely instruct representatives to bring another copy to the hearing since it is so likely that the mailed records will not have been placed in the file.

Also, claimants wait many months for a hearing and, as ALJ McDonald noted, medical providers cannot be asked repeatedly to update records. As a result, initial requests may occur when claimants first retain representation and then again closer to the hearing. However, the current regulations require only a 20-day notice. As a result, despite our intensive efforts to obtain updated records for the ALJ, it is not at all certain that they can be obtained prior to the hearing. If the records are obtained, it usually will be too close to the hearing date to send them by mail. We believe that a long notice period will significantly improve the earlier submission of evidence. In the NOSSCR comments to the proposed rule, we recommended a 90-day notice.

Another reason for submission of evidence at the hearing is that representatives frequently are prohibited by certain OHAs from reviewing the evidence file until the hearing is scheduled. And, until the file is reviewed, they cannot determine exactly what additional records development is needed. This problem has been exacerbated by the increase in the use of video teleconferencing (VTC) for hearings. This means that the ALJ will be located at a different location than the claimant. While the representative should have access to the file before it is transferred to the ALJ's OHA, this usually does not occur. As a result, representatives are in the unfortunate position of having to negotiate with distant OHAs for access to the exhibit files. The distant OHAs respond in various ways, including sending the file but only two weeks before the hearing or sending only a List of Exhibits but not the actual records.

5. With respect to the 20-day rule for submission of evidence, why isn't the "good cause" exception sufficient protection for claimants? Could your objections to other deadlines in the proposed rule be overcome by adding "good cause" exceptions?

"Good cause" decisions are completely within the discretion of the adjudicator. If the ALJ finds no good cause and rejects the evidence, a claimant will have no recourse to have the evidence considered, other than to file an appeal to federal court or simply abandon the claim. Under the proposed rule, claimants will have less than 25 days after receiving the hearing notice (45-day hearing notice requirement less 20 days to submit evidence before the hearing) to submit all updated medical records. However, nothing requires medical providers to turn over records this quickly. Claimants will then be at the mercy of ALJs to find good cause. Some will do so. But others may rigidly enforce the new 20-day deadline and refuse to consider any medical evidence submitted within that time limit and even deny the claim based on an incomplete medical record.

If the ALJ's discretion is abused, the claimant will have no recourse within the agency, but instead will have to file suit in federal court where a district court judge will be asked to decide not whether the evidence proves disability, but whether the ALJ was wrong to refuse to consider the evidence. As a result, the 20-day time limit will result in decisions based on incomplete records which cannot be repaired and will lead to unnecessary litigation.

A good cause exception to the 20-day rule also may be more burdensome not only for claimants and representatives but also for ALJs. If all necessary evidence has not been received at least 20 days before the hearing, it may be necessary to ask the ALJ for a good cause determination and/or to issue a subpoena. Since it is extremely unlikely that *all* evidence will be obtained more than 20 days before the hearing, requesting a good cause determination and/or that subpoenas be issued may become a routine matter at hearings. The ALJ will need to address these issues, leading to more litigation over these tangential, yet crucial, matters and ultimately leading to longer hearings.

These results are not only unfair to claimants but are also administratively inefficient and thus do not advance the Commissioner's goals.

Extending the use of good cause to other time limits in the proposed rule is not helpful to claimants for the reasons discussed above, primarily, that it is a discretionary decision for which the claimant has no recourse.⁵ We believe that such unlimited discretion will not improve the system but will make it worse.

6. What barriers and obstacles do claimants face in pursuing an appeal in Federal court?

We support the current system of judicial review. We believe that both individual claimants and the system as a whole benefit from the federal courts deciding Social Security cases. Over the years, the federal courts have played a critical role in protecting the rights of claimants. The system is well-served by regular, and not specialized, federal judges who hear a wide variety of federal cases and have a broad background against which to measure the reasonableness of SSA's practices. Under the current system, the courts are more geographically accessible to all individuals and give them an equal opportunity to be heard by judges of high caliber.

However, as noted by Judge McKibben in his testimony at the September 27th hearing, there is a large drop-off in appeals from the Appeals Council to federal court under the current process. Based on our experience, the two main factors are (1) the complexity of the process, which intimidates claimants (especially those who are unrepresented), and (2) the cost, which is prohibitive for many individuals. Overall, it is very difficult for a claimant to win a case in court without the assistance of legal counsel.

As noted by Judge McKibben, there are other factors contributing to the decision not to appeal to court. These include the fact that some attorneys do not take cases to federal court; some representatives are not attorneys; and many attorneys do not take cases to federal court if they did not represent the claimant at the hearing. Judge McKibben noted another important factor: the existence of the right to seek administrative review of unfavorable ALJ decisions.

Federal court appeals are more costly than appealing to the Appeals Council. The procedure to request review by the Appeals Council is relatively simple. SSA has a one-page form that can be completed and filed in any Social Security office, sent by mail, or faxed. In contrast, the procedure for filing an appeal to federal district court is much more complicated and, unless waived, there is a \$250 filing fee, which may be cost-prohibitive for a claimant.

⁵ Not all actions by SSA give the individual the right to administrative and judicial review. See 20 C.F.R. §§ 404.902 and 416.1402.

While the fee may be waived, it involves filing a motion to proceed *in forma pauperis* and then waiting for a decision granting the motion. Although court personnel are generally helpful, pro se claimants are nevertheless intimidated by this process.

Federal court appeals are more complex than appealing to the Appeals Council. In contrast to the filing of a simple one-page form to request review by the Appeals Council, filing an appeal and following through with the case in federal court is much more complex and governed by procedural rules since it is an adversarial process. A formal Complaint must be filed, which then must be served on the appropriate federal officials. A transcript of the administrative proceedings is prepared by the agency and is then served on the plaintiff/claimant. That is followed by a briefing schedule set by the court. The plaintiff/claimant must then wait for a decision by the court, which can be a long wait depending on the press of other cases before the court. And if there is no intermediate administrative appeals process, the delays may be even longer than those that currently exist. As noted by Judge McKibben in his testimony:

“[T]he acceleration of district court review of disability claim denials may result in more costs and further delays for claimants because it merely shifts the time for considering such claims from the administrative process to the courts.”

It is also important to note that many claimants have impairments or other limitations that affect their ability to navigate the system, e.g., they have mental impairments, are illiterate, are not fluent in English, or are homeless. Filing an appeal to an administrative body like the Appeals Council is much easier and far less intimidating than filing an appeal in federal court.

Another obstacle for claimants is that the record is closed once the case is at the federal court level and new evidence cannot be considered by the court. Unlike the *de novo* standard used by ALJs in making findings of fact, the courts are limited, by statute, to determining whether findings made in the administrative process are supported by substantial evidence.⁶ The “substantial evidence” standard is considered very deferential in contrast to the *de novo* standard. A court may remand the case back for SSA (not the court) to consider new evidence but only if it is new, material, and there is good cause for the failure to submit it in the prior administrative proceedings.⁷ The courts have been strict in applying this provision and such remands occur very infrequently. The strict rules in the July 27th proposal are certainly exacerbated by the limitations at the federal court level regarding new evidence.

Thank you for this opportunity to respond to these questions.

Sincerely,

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President
National Organization of Social Security
Claimants’ Representatives (NOSSCR)

⁶ 42 U.S.C. § 405(g).

⁷ This is known as a “sentence six” remand because it is authorized by the sixth sentence in 42 U.S.C. § 405(g).