SSA Has Abolished the Treating Physician Rule—Learn About the Recent Regulatory Changes Impacting Medical Source Evidence

Sarah Bohr, Esq.
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1. Highlights of the Revised Regulations on Medical Sources

   A. Introduction

   1. SSA has substantially revised its regulations pertaining to medical evidence, effective March 27, 2017. See 82 Fed. Reg. 5844-5884 (Jan. 18, 2017). As noted in the summary of the final rules:

   We are revising our medical evidence rules. The revisions include redefining several key terms related to evidence, revising our rules about acceptable medical sources (AMS), revising how we consider and articulate our consideration of medical opinions and prior administrative medical findings, revising our rules about medical consultants (MC) and psychological consultants (PC), revising our rules about treating sources, and reorganizing our evidence regulations for ease of use.

   82 Fed. Reg. at 5844.

   2. The new regulations are effective for claims filed on March 27, 2017 and after. The existing regulations continue to apply for claim filed before March 27, 2017. See 20 C.F.R. § 404.1527, 417.927.

   3. Highlights of the new regulations include:

   a. Adjudicators will give no special weight to the medical opinions of a claimant’s treating sources. Instead, medical opinions and prior administrative medical findings will be evaluated equally for “persuasiveness” based most importantly on consistency and supportability.

   b. Physicians Assistants (PAs) and Advance Practice Registered Nurses (APRNs) are now included in the list of Acceptable Medical Sources (AMSs). Licensed audiologists and optometrists can also be AMSs for certain purposes within the scopes of their practices.

   c. Adjudicators will give no special weight to the disability decisions of other governmental agencies, including the VA, but will consider and evaluate the medical evidence that was submitted to that agency in support of that decision.

   d. SSA has rescinded SSR 96-2p, 96-5p, 96-6p and 06-03p and issued the new SSR 17-2p addressing findings of medical equivalence. This Ruling is discussed infra.
B. Overview of Provisions Regarding Acceptable Medical Sources

1. New acceptable medical sources (AMS) for claims filed on or after March 27, 2017. See 20 C.F.R. §§ 404.1502, 416.902.
   a. “Licensed optometrist for impairments for impairments of visual disorders, or measurement of visual acuity and visual fields only, depending on the scope of practice in the State in which the optometrist practices.”
   b. “Licensed audiologist for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only.”
   c. “Licensed Advanced Practice Registered Nurse or other licensed advanced practice nurse with an other title, for impairments within his or her licensed scopes of practice.” In the NPRM, SSA stated that this includes four types of medical sources—Certified Nurse Midwife, Nurse Practitioner, Certified Registered Nurse Anesthetist, and Clinical Nurse Specialist. See 81 Fed. Reg. at 62568.
   d. “Licensed Physician Assistant for impairments within his or her licensed scope of practice.”

2. SSA declined to add Licensed Clinical Social Workers as AMSs as SSA found that the licensing requirements for therapists did not have a “similar level of consistency or rigor in terms of education, training, certification and scope of practice” as ARNP, audiologists and PAs. 81 Fed. Reg. at 5847.

3. Which providers are considered AMSs is important because only AMSs can provide objective medical evidence that establishes the existence of a medically determinable impairment. However, the prefatory matter to the final rule does state that adjudicators will articulate “how they consider medical opinions from all medical sources, regardless of whether or not the medical source is an AMS in final 404.1520c and 416.920c.” 82 Fed. Reg. 5844.

4. “Because of these revisions, these final rules retain only two programmatic distinctions between AMSs and medical sources who are not AMSs in our regulations for claims filed on or after March 27, 2017. First, we need objective medical evidence from an AMS to establish the existence of a medically determinable impairment(s) at step 2 of the sequential evaluation process. Second, in a few instances, we need specific evidence from an AMS to establish that an individual’s impairment meets a Listing.” 82 Fed. Reg. at 5845.

C. Provision Regarding Objective Medical Evidence and Medical Opinions

1. In the new regulations, SSA sets forth four categories of evidence: (1) objective medical evidence; (2) medical opinion; (3) other medical evidence; and (4) evidence from nonmedical sources. 20 C.F.R. §§ 404.1513, 416.913. The regulations revise the definition of objective medical evidence, limit the definition of a “medical opinion,” to only functional limitations (the ability to “perform physical demands of work activities,” “perform mental demands of work activities,” perform other demands of
work such as “seeing, hearing, or using other senses”; and “adapt to environmental conditions . . .”); and call the balance of medical opinion evidence “other medical evidence” (i.e., judgments about the nature and severity of impairments, medical history, clinical findings, diagnoses and treatment prescribed with response or prognosis). Id. The last category, “evidence from nonmedical sources,” is “any information or statement(s) from a nonmedical sources (including you) about any issue in your claim” which may come from the “nonmedical sources either directly” or “indirectly, such as from forms we receive and our administrative records. Id.

2. The comments to the new regulations include the following chart explaining the categories of evidence:

<table>
<thead>
<tr>
<th>Category of Evidence</th>
<th>Source</th>
<th>Summary of definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective medical evidence</td>
<td>Medical sources</td>
<td>Signs, laboratory findings, or both.</td>
</tr>
<tr>
<td>Medical opinion</td>
<td>Medical sources</td>
<td>A statement about what an individual can still do despite his or her impairment(s) and whether the individual has one or more impairment-related limitations or restrictions in one or more specified abilities.</td>
</tr>
<tr>
<td>Other medical evidence</td>
<td>Medical sources</td>
<td>All other evidence from medical sources that is not objective medical evidence or a medical opinion.</td>
</tr>
<tr>
<td>Evidence from nonmedical sources</td>
<td>Nonmedical sources</td>
<td>All evidence from nonmedical sources.</td>
</tr>
<tr>
<td>Prior administrative medical finding</td>
<td>MCs and PCs</td>
<td>A finding, other than the ultimate determination about whether the individual is disabled, about a medical issue made by an MC or PC at a prior administrative level in the current claim.</td>
</tr>
</tbody>
</table>

82 Fed. Reg. at 5851.

3. In comments to the new rules, SSA explained that “[o]ur adjudicators will continue to assess an individual’s ability to function under these final rules using evidence we receive from all sources, including nonmedical sources.” 82 Fed. Reg. at 5850.
4. “Objective medical evidence means signs, laboratory findings, or both.” 20 C.F.R. §§ 404.1502, 416.902. In the comments, SSA clarified that “‘one or more,’ signs, ‘one or more’ laboratory findings, or both constitute objective medical evidence.” 82 Fed. Reg. at 5844.

5. “Signs means one or more 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.” 20 C.F.R. §§ 404.1502, 416.902.

6. SSA also explained in its comments that symptoms, diagnosis and prognosis are no longer part of the definition of a medical opinion since they “do not describe how an individual functions.” 82 Fed. Reg. at 5850.

D. Overview of Provisions Regarding Weight to Medical Sources

1. For claims filed before March 27, 2017, new 20 C.F.R. §§ 404.1527(f) and 416.927(f) explain how SSA will consider and articulate its consideration of opinions from non AMS medical sources and nonmedical sources, incorporating language from SSR 06-03, which will be rescinded.

2. Among the most important changes in new regulations on medical evidence is that the “treating source” policy will not be applied to claims filed on or after March 27, 2017. See 20 C.F.R. §§ 404.1520c(a), 416.920c(a) (“[w]e 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”). In comments filed with the new regulations, SSA states that since the treating source rule was adopted in 1991, “the healthcare delivery system has changed in significant ways that require us to revise our policies in order to reflect this policy” as “[m]any individuals receive health care from multiple medical sources” and “less frequently develop a sustained relationship with one treating physician.” 82 Fed. Reg. at 5853. “[M]any of the medical sources from whom an individual may seek evaluation, examination, or treatment do not qualify to be ‘treating sources’ as defined in current 404.1502 and 416.902 because they are not AMSs.” Id.

3. The comments also reference court decisions which rely on articulation errors, stating:

Courts reviewing claims under our current rules have focused more on whether we sufficiently articulated the weight we gave treating source opinions, rather than on whether substantial evidence supports our final decision. As the Administrative Conference of the United States’ (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. 82 Fed. Reg. at 5853.
4. Instead of the treating source rule, adjudicators will now focus on the “persuasiveness” of evidence from different medical sources, based on “supportability and consistency.” See 20 C.F.R. §§ 404.1420c(a), 416.920c(a) which are contained in the Appendix to these materials. As SSA explained in the comments:

our experience adjudicating claims using the treating source rule since 1991 has shown us that the two most important factors for determining the persuasiveness of medical opinions are consistency and supportability. The extent to which a medical source's opinion is supported by relevant objective medical evidence and the source's supporting explanation—supportability—and the extent to which the opinion is consistent with the evidence from other medical sources and nonmedical sources in the claim—consistency—are also more objective measures that will foster the fairness and efficiency in our administrative process that these rules are designed to ensure. These same factors also form the foundation of the current treating source rule, and we believe that it is appropriate to continue to keep these factors as the most important ones we consider in our evaluation of medical opinions and prior administrative medical findings. . . .

Furthermore, to reflect modern healthcare delivery, we will articulate in our determinations and decisions how we consider medical opinions from all of an individual's medical sources, not just those who may qualify as “treating sources” as we do under current 404.1527(c)(2) and 416.927(c)(2).

Moreover, these final rules in 404.1520c(c)(3) and 416.920c(c)(3) retain the relationship between the medical source and the claimant as one of the factors we consider as we evaluate the persuasiveness of a medical opinion. These final rules also continue to allow an adjudicator to consider an individual's own medical source's medical opinion to be the most persuasive medical opinion if it is both supported by relevant objective medical evidence and the source's explanation, and is consistent with other evidence, as described in final 404.1520c and 416.920c.

Finally, our current rules do not create an automatic hierarchy for treating sources, examining sources, then nonexamining sources to which we much mechanically adhere.

82 Fed. Reg. at 5853.

5. The new regulations also address “How we articulate our consideration of medical opinions and prior administrative medical findings” which requires articulation in the determination or decision “how persuasive we find all of the medical opinions
and all of the prior administrative medical findings in your case record.” 20 C.F.R. §§ 404.1420c(b), 416.920c(b). Regarding “source-level articulation,” the regulation states that “[b]ecause 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.” 20 C.F.R. §§ 404.1420c(b)(1), 416.920c(b)(1).

Instead, the regulation explains:

when a medical source provides multiple medical opinion(s) or prior administrative medical finding(s), we will articulate how we considered the medical opinions or prior administrative medical findings from that medical source together in a single analysis using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. We are not required to articulate how we considered each medical opinion or prior administrative medical finding from one medical source individually.

Id.

6. The factors of supportability and consistency are the most important factors considered in determining the persuasiveness of a medical opinion. 20 C.F.R. §§ 404.1420c(b)(2), 416.920c(b)(2). The adjudicator must explain how “we considered the supportability and consistency factors for a medical source’s opinion or prior administrative medical findings” in the determination or decision. Id. The adjudicator may also, but is not required to, consider the other factors set forth in 20 C.F.R. §§ 404.1420c(c)(3)-(5), 416.920c(c)(3)-(5) and discussed below. In the comments to the final regulations, SSA explains that the articulation of supportability and consistency factors “generally includes an assessment of the supporting objective medical evidence and other medical evidence, and how consistent the medical opinion or prior administrative medical findings is with the other evidence in the claim.” 82 Fed. Reg. at 5859.

7. In cases where two or more medical opinions or prior administrative medical findings about the same issue are equally well-supported and consistent, but are not “exactly the same, we will articulate how we considered the other most persuasive factors in paragraphs (c)(3) through (c)(5) of this section” in the determination or decision. 20 C.F.R. §§ 404.1420c(b)(3), 416.920c(b)(3). These other factors are the (1) “relationship with the claimant” (length of the treatment relationship, examining relationship, frequency of examinations, purpose of the treatment relationship, and extent of the treatment relationship); (2) specialization of the source; and (3) “other factors” such as “understanding [SSA] policy” and “familiarity with the record.” 20 C.F.R. §§ 404.1420c(c)(3)-(5), 416.920c(c)(3)-(5). Regarding the last factor, the regulations state that “[w]hen we consider a medical source’s familiarity with the other evidence in a claim, we will also consider whether new evidence we receive after the medical
source made his or her medical opinion or prior administrative medical finding makes the medical opinion or prior administrative medical finding more or less persuasive.” 20 C.F.R. §§ 404.1420c(c)(5), 416.920c(c)(5).

8. In the comments to the final rules, SSA explains that adjudicators are required to articulate our consideration of medical opinions from all sources regardless of whether the medical source is an AMS. 82 Fed. Reg. 5855. However, SSA is “not required to articulate how we considered evidence from nonmedical sources using the requirements in” 20 C.F.R. §§ 404.1520c(a)-(c) and 416.920c(a)-(c) of the regulations, according to new 404.1520c(d) and 416.920c(d).

9. The comments also emphasize that there is not an inherent persuasiveness to evidence from MCs, PCs, or CE sources over an individual’s own medical source(s), and vice versa, and to highlight that we continue to consider a medical source’s longstanding treatment relationship with the individual.” 82 Fed. Reg. at 5844.

10. The final rules also recognize that “evidence from a medical source who has a longstanding treatment relationship with an individual may contain some inconsistencies over time due to fluctuations in the severity of an individual’s impairments.” 82 Fed. Reg. at 5857.

11. The comments also indicate that, in addition, the prefatory matter to the final rule states “it is never appropriate under our rules to ‘credit-as-true’ any medical opinion” as this rule “supplants the legitimate decisionmaking authority of our adjudicators. . . .” 82 Fed. Reg. at 5858, 5860.

E. Overview of Provisions Regarding Disability Determinations from Other Governmental and Non-Governmental Agencies.

1. The new regulation also address disability determinations from other governmental agencies and non-governmental entities, such as Veterans Affairs, the Department of Defense, the Department of Labor, the Office of Personnel Management, State agencies, and private insurers including workers compensation providers. “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.” 20 C.F.R. §§ 404.1504, 416.904

2. Thus, in claims filed on or after March 27, 2017, 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 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.” 20 C.F.R. §§ 404.1504, 416.904

3. In response to comments asking how this rule fits with SSA’s “all-evidence” policy, the comments state that claimants and representatives still must submit or inform the agency about all evidence that “relates” to disability determination, even though
these decisions “may not relate to whether or not an individual is blind or disabled under our rules.” 82 Fed. Reg. at 5849. Since such evidence is considered, the comments explain:

When an individual informs us about another government agency’s or nongovernmental entity’s decision, we will identify and consider, or will assist in developing, the supporting evidence that the other agency or entity used to make its decision. We may also use that evidence to expedite processing of claims for Wounded Warriors and for veterans with a 100% disability compensation rating, as we do under our current procedures.

Id. See 20 C.F.R. §§ 404.1504, 416.904 (“we will consider all of the supporting evidence underlying the other governmental agency or nongovernmental entity’s decision that we receive as evidence in your claim in accordance with § 404.1513(a)(1) [§ 416.913(a)(1) for SSI claims].

F. Overview of Provisions Regarding “Issues Reserved to the Commissioner.”

1. SSA’s new policy on statements reserved to the Commissioner is discussed in 20 C.F.R. §§ 404.1520b(c)(3), 416.920b(c)(3). “Statements on issues reserved to the Commissioner” include the following: (1) statements that a claimant is or is not disabled, blind, able to work or able to perform regular or continuing work; (2) statements regarding whether a claimant has a severe impairment; (3) statements regarding whether or not an impairment meets the duration requirement; (4) statements regarding whether an impairment meets or equals a listed impairment; (5) statements “about what your [RFC] is using our programmatic terms about function exertional levels . . . .”; (6) statements about whether the claimant’s RFC prevents performing his or her past relevant work; (7) statements that a claimant does or does not meet a Grid Rule; and (8) statements about whether the claimant’s disability ends or continues in termination cases.

2. Adjudicators are no longer required to articulate how they consider statements on such issues. As noted in the comments to the final regulations:

Because we are responsible for making the determination or decision about whether an individual meets the statutory definition of disability, these statements are neither valuable nor persuasive for us. Therefore, our adjudicators will continue to review all evidence and consider the context of a source’s use of terms in our regulations, but they are not required to articulate how they considered statements on an issue reserved to the Commissioner.

82 Fed. Reg. at 5831. See 20 C.F.R. §§ 404.1520b(c), 416.920b(c) (“we will not provide any analysis about how we considered such evidence in our determination or decision . . . .”)

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3. In the comments to the new regulations, SSA stated that the agency “will not consider an entire document to be a statement on an issue to the Commissioner simply because the document contains a statement on an issue that is reserved to the Commissioner.” 82 Fed. Reg. at 5851.

G. Recision of the Following Rulings

1. SSR 96-2p: Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions
2. SSR 96-5p: Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner
3. 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 (replaced by SSR 17-2p, discussed below)
4. 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

II. New Social Security Ruling 17-2P Effective for New Claims Filed on or After March 27, 2017

A. Overview of SSR 17-2P7

1. Rescinds and replaces SSR 96-6p
2. Addresses medical equivalence to listed impairments
3. Clarifies who is responsible for making determination of equivalence
4. Describes articulation requirements

B. Overview of Ruling

1. SSR 17-2p, which rescinds and replaces SSR 96-6p, first reaffirms that impairments medically equal listed impairments if they are at least equal in severity and duration to the listed impairments’ criteria. The Ruling explains that medical equivalence can be found in any of three ways:

   a. In cases involving an impairment that is described in the listings but one or more specified findings are absent or insufficiently severe, “there are other findings related to the impairment that are at least of equal medical significance to the required criteria”;
   b. Where the impairment is not described in the listings, but comparing the findings with those for closely analogous listed impairments reveals findings “at least of equal medical significance to those of a listed impairment”; or
c. Where findings related to a combination of impairments, once compared to the findings required for closely analogous listed impairments, have equal or greater medical significance than those of a listed impairment.

2. SSR 17-2p also addresses the matter of who decides listing equivalence. It states that, while at the initial and reconsideration levels the issue is determined by medical or psychological consultants, at the hearings level it is ALJs “and some attorney advisors” who make the determination of equivalence. To assist in the evaluation, adjudicators “may” request and consider medical expert evidence. Similarly, where the Appeals Council issues a decision, it “may ask its medical support staff to help decide whether an individual’s impairment(s) medically equals a listing.”

3. SSR 17-2p clarifies that the issue of medical equivalence is reserved to the Commissioner. An adjudicator “is responsible for the finding of medical equivalence” and “must base his or her decision about whether the individual’s impairment(s) medically equals a listing on the preponderance of the evidence in the record.” However, adjudicators at the hearings and Appeals Council levels “must consider all evidence in making” the finding as to medical equivalence. Adjudicators are to consider expert testimony and interrogatories using the applicable rules for considering evidence.

4. SSR 17-2p provides that medical and psychological consultants’ findings from the initial or reconsideration levels are evidence that must be considered, and adjudicators must “articulate how they considered them in the decision.” The adjudicator will then consider listing equivalence under the three possible avenues described above.

5. Nevertheless, the Ruling states that where it is believed the evidence of record “does not reasonably support a finding that the individual’s impairment(s) medically equals a listed impairment, we do not require the adjudicator to obtain ME evidence or medical support staff input prior to making a step 3 finding that the individual’s impairment(s) does not medically equal a listed impairment.”

6. While an adjudicator cannot rely on an expert’s conclusory statement that medical equivalence is present, the adjudicator is not required to provide a detailed rationale for his or her own finding: generally, the adjudicator’s “statement that the individual’s impairment(s) does not medically equal a listed impairment constitutes sufficient articulation for this finding.”

7. Concerning articulation requirements in cases where medical equivalence is not found, the Ruling also states:

If an adjudicator . . . believes that the evidence already received in the record does not reasonably support a finding [of medical equivalence], the adjudicator is not required to articulate specific evidence supporting his or her finding that the individual’s impairment(s) does not medically equal a listed impairment.
Rather, “[a]n adjudicator’s articulation of the reason(s) why the individual is or is not disabled at a later step in the sequential evaluation process will provide rationale that is sufficient for a subsequent reviewer or court to determine the basis for the finding about medical equivalence at step 3.”

C. Key Components

1. **Medical equivalence is established in one of three ways.**

   SSR 17-2p explains that medical equivalence can be found in any of three ways. It is established where:

   (1) an impairment that is described in the listings but one or more specified findings are absent or insufficiently severe, “there are other findings related to the impairment that are at least of equal medical significance to the required criteria”;  
   (2) the impairment is not described in the listings, but comparing the findings with those for closely analogous listed impairments reveals findings “at least of equal medical significance to those of a listed impairment”; or  
   (3) where findings related to a combination of impairments, once compared to the findings required for closely analogous listed impairments, have equal or greater medical significance than those of a listed impairment.

2. **Determinations about equivalence must be based on a preponderance of the evidence of record.**

   SSR 17-2p provides that “the adjudicator is responsible for the finding of medical equivalence” and “must base his or her decision about whether the individual’s impairment(s) medically equals a listing on the preponderance of the evidence in the record.”

3. **The issue of medical equivalence is reserved to the Commissioner.**

   SSR 17-2 clarifies that the issue of medical equivalence is reserved to the Commissioner.

4. **All evidence must be considered in determining whether a listing is medically equaled.**

   The Ruling states that adjudicators at the hearings and Appeals Council levels “must consider all evidence in making” the finding as to medical equivalence. Adjudicators are to consider expert testimony and interrogatories using the applicable rules for considering evidence. The Ruling provides that medical and psychological consultants’ findings from the initial or reconsideration levels are evidence that must be considered, and adjudicators must “articulate how they considered them in the decision.”
5. Medical expert evidence is not required to make a finding that medical equivalence is not present.

The Ruling states that where it is believed the evidence of record “does not reasonably support a finding that the individual’s impairment(s) medically equals a listed impairment, we do not require the adjudicator to obtain ME evidence or medical support staff input prior to making a step 3 finding that the individual’s impairment(s) does not medically equal a listed impairment.”

6. No detailed rationale is mandated to find a listing has not been equaled.

SSR 17-2p provides that an adjudicator is not required to provide a detailed rationale, and generally the adjudicator’s “statement that the individual’s impairment(s) does not medically equal a listed impairment constitutes sufficient articulation for this finding.” The Ruling also states: that “[i]f an adjudicator . . . believes that the evidence already received in the record does not reasonably support a finding [of medical equivalence], the adjudicator is not required to articulate specific evidence supporting his or her finding that the individual’s impairment(s) does not medically equal a listed impairment.”

7. Although no detailed rationale is needed at step three, a sufficient rationale revealing the basis for the medical equivalence finding is to be provided at a later step.

The Ruling explicitly notes that “[a]n adjudicator’s articulation of the reason(s) why the individual is or is not disabled at a later step in the sequential evaluation process will provide rationale that is sufficient for a subsequent reviewer or court to determine the basis for the finding about medical equivalence at step 3.”

Appendix

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 (b)(2)(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 §§ 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 inherently neither valuable nor persuasive. Paragraphs (c)(1) through (c)(3) apply in claims filed (see § 404.614) on or after March 27, 2017. Because the evidence listed in paragraphs (c)(1) through (c)(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 § 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 (c)(3)(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 you have a severe impairment(s);
(iii) Statements about whether or not your impairment(s) meets the duration requirement (see § 404.1509);
(iv) Statements about whether or not your impairment(s) meets or medically equals any listing in the Listing of Impairments in Part 404, Subpart P, Appendix 1;
(v) 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);
(vi) Statements about whether or not your residual functional capacity prevents you from doing past relevant work (see § 404.1560);
(vii) Statements that you do or do not meet the requirements of a medical vocational rule in Part 404, Subpart P, Appendix 2; and
(viii) Statements about whether or not your disability continues or ends when we conduct a continuing disability review (see § 404.1594).

§ 404.1520c How we consider and articulate medical opinions and prior administrative medical findings for claims filed on or after March 27, 2017.

For claims filed (see § 404.614) on or after March 27, 2017, the rules in this section apply. For claims filed before March 27, 2017, the rules in § 404.1527 apply.

(a) How we consider medical opinions and prior administrative medical findings. 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 (c)(5) of this section, as appropriate. The most important factors we consider when we evaluate the persuasiveness of medical opinions and prior administrative medical findings are support ability (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) How we articulate our consideration of medical opinions and prior administrative medical findings. We will articulate in our determination or decision how persuasive we find all of the medical opinions and all of the prior administrative medical findings in your case record. Our articulation requirements are 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 multiple medical opinion(s) or prior administrative medical finding(s), we will articulate how we considered the medical opinions or prior administrative medical findings from that medical source together in a single analysis using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. We are not required to articulate how we considered each medical opinion or prior administrative medical finding from one medical source individually.

(2) Most important factors. The factors of support ability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section) are the most important factors we consider when we determine how persuasive we find a medical source's medical opinions or prior administrative medical findings to be. Therefore, we will explain how we considered the support ability and consistency factors for a medical source's medical opinions or prior administrative medical findings in your determination or decision. We may, but are not required to, explain how we considered the factors in paragraphs (c)(3) through (c)(5) of this section, as appropriate, when we articulate how we consider medical opinions and prior administrative medical findings in your case record.

(3) Equally persuasive medical opinions or prior administrative medical findings about the same issue. When we find that two or more 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 (c)(5) of this section for those medical opinions or prior administrative medical findings in your determination or decision.

(c) Factors. We will consider the following factors when we consider the medical opinion(s) and prior administrative medical finding(s) in your case:

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

(3) **Relationship with the claimant.** This factor combines consideration of the issues in paragraphs (c)(3)(i) through (v) of this section.

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

   (ii) **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).

   (iii) **Purpose of the 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).

   (iv) **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).

   (v) **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.

(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 in the relevant area of specialty.

(5) **Other factors.** We will consider other factors that tend to support or contradict a medical opinion or prior administrative medical finding. This includes, but is not limited to, evidence showing a medical source has familiarity with the other evidence in the claim or an understanding of our disability program’s policies and evidentiary requirements. When we consider a medical source’s familiarity with the other evidence in a claim, we will also consider whether new evidence we receive after the medical source made his or her medical opinion or prior administrative medical finding makes the medical opinion or prior administrative medical finding more or less persuasive.

(d) **Evidence from nonmedical sources.** We are not required to articulate how we considered evidence from nonmedical sources using the requirements in paragraphs (a)–(c) in this section.
Endnotes:

1. 20 C.F.R. § 404.1513(a) defining categories of evidence, states:

(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 March 27, 2017). 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 opinion. 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, or pace; carrying out instructions; or responding appropriately to supervision, co-workers, or work pressures in a work setting;

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

(iv) Your ability to adapt to environmental conditions, such as temperature extremes or fumes. (For claims filed (see § 404.614) before March 27, 2017, 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 March 27, 2017, other medical evidence does not include a diagnosis, prognosis, or a statement that reflects a judgment(s) about the nature and severity of your impairment(s)).

(4) Evidence from nonmedical sources. Evidence from nonmedical sources is any information or statement(s) from a nonmedical source (including you) about any issue in your claim. We may receive evidence from nonmedical sources either directly from the nonmedical source or indirectly, such as from forms we receive and our administrative records.
(5) *Prior administrative medical finding.* A prior administrative medical finding is a finding, other than the ultimate determination about whether you are disabled, about a medical issue made by our Federal and State agency medical and psychological consultants at a prior level of review (see § 404.900) in your current claim based on their review of the evidence in your case record, 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.

See also 20 C.F.R. § 416.413(a) pertaining to SSI claims.

2. A prior administrative medical finding is a:

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


3. These are medical sources who are State or Federal agency medical consultants or psychological consultants.

4. New 20 C.F.R. §§ 404.1527(f), 416.927(f), applicable for claims filed before March 27, 2017, addresses SSDI's policies set forth in repealed SSR 06-03p regarding consideration and articulation of opinions from medical sources who are not acceptable medical sources and from nonmedical sources, and states:

(f) *Opinions from medical sources who are not acceptable medical sources and from non-medical sources.*
(1) **Consideration.** Opinions from medical sources who are not acceptable medical sources and from nonmedical sources may reflect the source’s judgment about some of the same issues addressed in medical opinions from acceptable medical sources. Although we will consider these opinions using the same factors as listed in paragraph (c)(1) through (c)(6) in this section, not every factor for weighing opinion evidence will apply in every case because the evaluation of an opinion from a medical source who is not an acceptable medical source or from a nonmedical source depends on the particular facts in each case. Depending on the particular facts in a case, and after applying the factors for weighing opinion evidence, an opinion from a medical source who is not an acceptable medical source or from a nonmedical source may outweigh the medical opinion of an acceptable medical source, including the medical opinion of a treating source. For example, it may be appropriate to give more weight to the opinion of a medical source who is not an “acceptable medical source” if he or she has seen the individual more often than the treating source, has provided better supporting evidence and a better explanation for the opinion, and the opinion is more consistent with the evidence as a whole.

(2) **Articulation.** The adjudicator generally should explain the weight given to opinions from these sources or otherwise ensure that the discussion of the evidence in the determination or decision allows a claimant or subsequent reviewer to follow the adjudicator’s reasoning, when such opinions may have an effect on the outcome of the case. In addition, when an adjudicator determines that an opinion from such a source is entitled to greater weight than a medical opinion from a treating source, the adjudicator must explain the reasons in the notice of decision in hearing cases and in the notice of determination (that is, in the personalized disability notice) at the initial and reconsideration levels, if the determination is less than fully favorable.

5. This regulation is contained in the Appendix to these materials.
6. These regulations are contained in the Appendix, *supra*.
7. This is an excerpt from *Sarah Bohr’s Pocket Guide to Key Social Security Rulings 8th Edition* which annotates key rulings issued by SSA through May 2017 and is available from the presenter.