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# *the* NADE ADVOCATE

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A Publication of the National Association of Disability Examiners

Volume 21, Number 4

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## Commissioner Barnhart Speaks To NADE Conference; Katrina Disaster Tests Electronic Process

*by Mike O'Connor, Michigan DDS*

***"I think that conferences like these are vital to ensuring that major issues are covered and issues are addressed, as well as re-energizing our workforce."***

*- Commissioner JoAnne B. Barnhart*

Attendees at the NADE National Training conference in September 2005 were able to hear first hand from the Commissioner of Social Security Jo Anne B. Barnhart regarding issues of critical importance to NADE members. Although the Commissioner was unable to take questions on the proposed rules for a new disability determination process since the comment period for the NPRM was still open, she did indicate that she was very interested to get NADE's feedback and hear from NADE members. She encouraged all attendees to provide comments regarding the proposed changes through appropriate channels established for the process.

The Commissioner provided a quick overview of the NPRM highlighting the proposed changes to the disability determination process. Special quick decision units will be on-site in the DDSs. Federal expert units will include medi-

cal specialists plus vocational experts to assist with complex medical and vocational case adjudication issues. These experts will be available to all components involved in case adjudication. The reconsideration step will be eliminated and in its place, a claimant's first appeal step will be to a reviewing official (RO). The RO will be a federal employee and an attorney.



*President Martha Marshall greets Commissioner Barnhart.*

There will still be a *de novo* hearing by an Administrative Law Judge (ALJ). Once the ALJ's decision has been finalized, it will be considered the final decision by the agency unless appealed to federal District Court. The case record will be closed once the ALJ issues his/her decision. The Appeals Council will be phased out as an appeal step and will be replaced as a new entity called a Decision Review Board (DRB). The DRB will review ALJ dismissals and other decisions for quality and consistency.

The Commissioner also commented on the various demonstration projects proposed in the new rules. She stated that SSA is looking for ways to establish earlier opportunities for disabled applicants to work other than the Ticket to Work program, which is available only to individuals once they have been determined disabled. SSA plans to do some demonstration projects to assist individuals earlier in the disability application process. Demonstration projects will provide applicants with access to needed health care and/or rehabilitation if the disability applicant wishes to continue to work, rather than waiting until he/she is determined disabled and then becomes eligible for the "Ticket" program.

Ms. Barnhart praised the hard-working members of the DDS for all they do, as well as the SSA employees response during the recent Hurricane Katrina disaster. SSA set up a temporary office in the Astrodome and SSA employees worked around the clock to help evacuees despite the fact that many employees

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## President's Message

Many thanks to the Idaho Chapter of NADE for hosting the 2005 NADE National Training Conference in



September! I know that those of you who were able to attend would agree that it was a wonderful experience filled with many opportunities to learn, network with peers, and share ideas about best business practices and disability policy. In this time of ongoing change in the disability program, I feel it is vitally important to connect with co-workers and colleagues to share such ideas and suggestions, and learn more about what the future holds for the Social Security Disability program.

NADE training conferences offer unique opportunities to learn and communicate with peers. They offer programs which are topical and relevant to issues we face on a daily basis. The Boise conference was an excellent example of that, with a wide range of medical, SSA, and inspirational speakers. Kudos on a job well done to the conference planners, the Idaho NADE Chapter, and Roy Valdez, Idaho DDS Director.

It's all about teamwork, and nowhere was that more apparent than on the whitewater raft trip that was enjoyed by fellow NADE members prior to the conference. Hanging on for dear life at times, confident in calmer waters, and working together to move forward, the raft trip can be compared to being in the workplace. Quite an adventure, and very fulfilling!

As you may know, the New Board met late into the evening on the last day of the conference, and was able to accomplish many things. Thanks to the pre-planning and enthusiasm of the Tennessee and Kentucky Chapters, conference bids have been accepted, carrying us through 2009! The fact that we are able to plan training conferences this far into the future is indicative of a tremendous amount of administrative support for NADE. This type of support is crucial as we strive to increase our membership and offer the type of training that cannot be found elsewhere.

Immediately after the conference, NADE was called upon to attend an SSA Policy Conference on Speech/Language impairments and possible listing addition. Future policy conferences such as this are also planned for Special Senses and Endocrine body systems. These conferences are attended by a mix of SSA policy makers, claimant advocates, and medical specialists in the area that is being discussed. This is yet another way in which NADE can voice your opinions on proposed policy changes.

After the Policy Conference, I attended a joint Congressional hearing on the Commissioner's Disability Process Improvement Initiative along with Marty Marshall, Terri Klubertanz, Mimi Wirtanen, and Chuck Schimmels. Although NADE was not called upon to testify, we submitted a Statement for the Record, which

*Continued on next page*

*The NADE Advocate is the official publication of the National Association of Disability Examiners. It provides a forum for responsible comments concerning the disability process. Official NADE positions are found in the comments by the NADE President and NADE Position Papers.*

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**Letters to the Editor** are welcomed and may be selected for inclusion in future issues. Please forward ideas for future *Advocate* topics to the editor or your Regional Publications Representative.

The next issue will be published in  
**Winter, 2006.**

All correspondence should be directed through your Regional Representative or directly to the  
**Advocate Editor by  
January 15, 2006**

You may e-mail articles  
in text format to  
**drhilton@cox.net**  
Please also forward a hard copy.

can be found on the NADE website, [www.nade.org](http://www.nade.org). The statement outlines NADE's views on the proposal, and work has also begun on our formal position paper. We have solicited input from you, as NADE members, to help in formulating our response. Thanks to those of you who have responded to that request.

I therefore encourage each and every NADE member to become more actively involved in the organization. When your opinion is solicited, provide it. Attempt to increase our membership for a stronger voice. Talk to your colleagues and discuss how the disability program can be improved. Share your ideas with the NADE Board. Encourage administrative support of NADE. It is only through our membership that our voice can be heard.

*Shari Bratt*  
NADE President



*The Presidents Reception honored attending Past NADE Presidents Debi Gardiner, Theresa Klubertanz, Martha Marshall, Marty Blum, and Susan LaMorte.*

### In Sympathy

**NADE extends its deepest sympathy to the family of Lenore Carlson, Associate Commissioner for the Office of Disability Determinations. She was a strong advocate for the DDS and the SSA Disability Program. She will be missed by all.**

### NADE CALENDAR OF EVENTS:

Mid Year Board Meeting	Madison Hotel	Washington DC	March 1-4, 2006
Quad Regional Conference (Mid-Atlantic/Northeast/Southeast/Southwest)	Sheraton Ocenfront	Virginia Beach VA	May 16-19, 2006
National Training Conference	Bahia Resort & Hotel	San Diego CA	Sept. 16-21, 2006

*Barnhart, continued from page 1*

themselves had lost everything due to the disaster. Many SSA offices in the region Hurricane Katrina hit were completely destroyed or unusable, including the SSA OHA and the Metairie LA DDS offices.

At the time of the conference, there were still 52 SSA and 26 DDS employees in the Hurricane Katrina disaster region who were unaccounted for and remained missing. (Since then all staff have been located.) As a testament to the Herculean efforts by SSA staff, Ms. Barnhart stated that 200 emergency payments for Katrina evacuees were processed in one day as opposed to typically only paying such benefits at the rate of 200 in one month. In addition, at the time of the conference, 43,000 temporary emergency benefits checks had been issued to Katrina evacuees since September 1st.

Ms. Barnhart then touched on the progress of eDIB (electronic disability). She stated that eDIB is the foundation for the success of any disability service process improvement initiatives. As sad as the recent hurricane disaster was, SSA has already realized some benefits from eDIB. The OHA office in Metairie, LA was completely flooded and the DDS office experienced significant damage. All eDIB cases were able to be immediately retrieved and worked electronically in the Baton Rouge, LA DDS office while waiting to be able to get into the buildings to retrieve the paper cases. Although the Hurricane Katrina disaster was devastating to many people, including many of our clients, the new electronic format showed how seamless a paperless disability process could work.

All states except New York have implemented eDIB. New York was expected to roll out eDIB on 10/31/05. At the time of the conference, five states had received certification to process all their initial cases paperless.

*NADE received a kind note  
from Commissioner Barnhart.*

eDIB pilot projects have been initiated across the nation to determine their cost effectiveness and impact on productivity. One such pilot is the dual monitor pilot which has been initiated in up to 1000 work stations nationwide. If the pilot is determined to be successful, dual monitors may become a standard for adjudication. Early results have been promising.

SSA is undertaking a monumental effort across the nation to educate medical record providers regarding SSA's new paperless disability determination process. SSA has established national contracts with some vendors and is making a major push to increase the amount of evidence that is submitted to SSA in an electronic format. Commissioner Barnhart explained that the more evi-

dence SSA receives electronically, the quicker claims can be processed as DDSs don't have to wait for the evidence to be imaged into the system - it is retrievable immediately to be electronically worked.

The Commissioner stated that there has been significant progress made in reducing workload pendings, particularly at the Office of Hearings and Appeals level. At the time of the conference, the number of ALJ cases pending nationally was 717,567. Additional ALJs have been hired, which has helped plus ALJs have increased productivity nationwide. ALJs now conduct an average of 2.6 hearings a day which is an increase of over 50% production from previous levels. Processing time has also decreased. Appeals that once took 447 days to process now currently take 250 days.

*Continued on page 7*

THE COMMISSIONER OF SOCIAL SECURITY  
BALTIMORE, MARYLAND 21235

September 20, 2005

Ms. Martha Marshall  
President  
National Association of Disability Examiners  
2704 Frank Street  
Lansing, MI 48911

Dear Martha:

Thank you for your warm welcome at the 2005 National NADE conference. It is always a pleasure to speak to your organization. I particularly enjoyed the question-and-answer session — I always get new ideas or creative suggestions to consider from your members.

I hope to see you again soon.

Sincerely,

*Jo Anne B. Barnhart*  
Jo Anne B. Barnhart

*I always enjoy my time  
with NADE!*

NADE Correspondence



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Commissioner of Social Security  
PO Box 17703  
Baltimore, MD 21235-7703

Dear Commissioner:

The National Association of Disability Examiners (NADE) has reviewed the proposed rule on Evidentiary Requirements for Making Findings About Medical Equivalence. We appreciate this opportunity to provide comments.

NADE is a professional association whose mission is to advance the art and science of disability evaluation. The majority of our members work in the state Disability Determination Service (DDS) agencies adjudicating claims for Social Security and/or Supplemental Security Income (SSI) disability benefits. In addition, our membership includes SSA Central Office and Regional Office personnel, attorneys, consulting physicians and psychologists, claimant advocates and others. It is the diversity of our membership, combined with our "hands on" experience which provides a unique and realistic perspective on the issues facing the Social and SSI disability programs today.

We understand that the changes proposed in this Notice of Proposed Rulemaking (NPRM) are not intended to be substantive or to affect how the DDSs process cases. For the most part we agree with that assessment. We support the emphasis on and specific discussion regarding the need to document the presence of a medically determinable impairment, and the clarification that an impairment cannot meet the listing based only on a diagnosis (404.1525d and 416.925d).

NADE does not support removing the clarifying phrase, "...signs, symptoms and laboratory findings..." . We do not agree that, "These descriptions of our listings are no longer accurate. For many years we have had listings that also include functional criteria." While an explicit level of function has come to play a larger role in defining listing-level impairments, the proposal seems to over-estimate the importance of "function". All listings do require, in some combination, symptoms, signs and/or laboratory findings. Additionally, any functional restriction(s) described in the listings must still result from the *impairment*; and the presence of the impairment must still be established by medical findings.

We do not support deleting the word, "medical" from the phrase, "medical opinion" in the last sentence of proposed 404.1526 c and 416.926 c. Opinions from these sources would obviously be medical opinions and it does not clarify the ruling to delete that word.

We propose adding "medical" before "history" and before "signs" in 404.1529 c and 416.925 c1 and c 4.

We would suggest replacing the proposed language, "...your treating or *nontreating* source,...." with the phrase, "....your treating source and others who have examined but not treated you..." We believe this wording would be better understood by the general public. If the proposed rule is intended (at least in part) to correct the interpretation in the Hickman decision that the phrase, "medical evidence only" excludes consideration of information from non-medical sources, we would suggest adding a supplemental sentence stating, "Information from you and others who know you and can provide information about your medical condition will also be considered".

NADE has long expressed the belief that individuals applying for Social Security and/or SSI disability benefits should receive the same decision regardless of where, or under what court jurisdiction, they live. We strongly support any efforts to assure that regulations are written in such a way that they are interpreted uniformly throughout the country and in all court jurisdictions. We appreciate this effort to clarify the issues raised in the Hickman decision and thank you for your consideration of our comments.

Sincerely,

Martha Marshall  
Martha A. Marshall  
NADE President

**NADE Correspondence**

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Commissioner of Social Security  
PO Box 17703  
Baltimore, MD 21235-7703

Dear Commissioner:

The National Association of Disability Examiners (NADE) has reviewed the proposed rule on *Revised Medical Criteria for Evaluating Visual Disorders*. We appreciate this opportunity to provide comments.

NADE is a professional association whose mission is to advance the art and science of disability evaluation. The majority of our members work in the state Disability Determination Service (DDS) agencies adjudicating claims for Social Security and/or Supplemental Security Income (SSI) disability benefits. In addition, our membership includes SSA Central Office and Regional Office personnel, attorneys, consulting physicians and psychologists, claimant advocates and others interested in disability evaluation. It is the diversity of our membership, combined with our "hands on" experience which provides a unique and realistic perspective on the issues facing the Social Security and SSI disability programs today.

The DDSs have struggled for years to find sources willing and able to perform visual field testing using the Goldmann or other kinetic perimetry. NADE strongly supports the decision to adopt recommendations of the National Research Council to use visual field measurements obtained with an automated static threshold perimetry test performed on a perimeter which meets SSA's specific requirements, while still accepting results obtained using Goldmann or other kinetic perimetry testing.

Due to its technical nature the lengthy and detailed discussion in Sections 2.00 6 and 102.00 6, ("*How Do We Measure Visual Fields?*") may be of limited use to the general public. However, the information provided is important, and valuable, for treating (MER) sources, consultants and adjudicators.

Although to date it has not been difficult for DDS's to obtain visual acuity testing based on Snellen methodology, we believe it is important that adjudicators understand how to evaluate results obtained using newer test charts. Clarifying that statutory blindness can be found when an individual is unable to read any of the letters on the 20/100 line, but not if they can read at least one letter on the 20/100 line, provides consistent guidance for all adjudicators, and should help promote consistency and uniformity in the evaluation of these claims.

We appreciate the clarification that pin-hole and visual evoked response testing are not to be used to establish visual acuity, that measurements obtained with a specialized lens will be used only if the individual has demonstrated the ability to use the specialized lens on a sustained basis, and that results obtained with telescopic lenses will not be used. Again, these changes provide consistent guidance for all adjudicators and should promote consistency and uniformity in the evaluation of these claims.

The information provided in 102.00 A 5 a ii, that tests such as the Landolt C test or the tumbling-E test can be used to evaluate young children who are unable to participate in testing using Snellen methodology, is good. Both of these tests are considered to be excellent tests for young children in determining visual acuity. In addition, the ability to use information about how a child fixes and follows a light to judge acuity is also an important addition to the listings. This information is helpful both for adjudicators and for treating and consulting ophthalmologists.



*Continued from previous page*

We appreciate clarification in this regulation that normal results from visual field screening tests, when these test results are consistent with other evidence in file, can be used to determine whether the impact of the visual disorder is severe.

The proposed listings eliminate the need to obtain visual fields for children with macular edema but still require visual fields for adults with macular edema. We believe this is inconsistent and unnecessary. Scotoma produced by macular edema will be minimal and there would be no need to obtain visual fields for this condition unless other ocular problems besides macular edema exist.

Although we agree that aphakia is rarely seen in current practice, NADE is concerned that removing this condition from calculations of visual acuity efficiency will disadvantage those claimants who, for whatever reason, are unable to obtain, or use, synthetic intraocular lenses or who cannot use contact lenses.

Childhood Listing 102.00 A 4 states, in part, “If there is a loss of visual acuity or visual fields, the cause of the loss must be documented” (emphasis added). This wording is the same as that found in Adult Listing 2.00 A 4, “*What Evidence Do We Need To Evaluate Visual Disorders, Including Those That Result In Statutory Blindness Under Title II*” and directly contradicts Childhood Listing 102.00 A 3 which states (as does Adult Listing 2.00 A 3), “For Title XVI, the only evidence we need to establish statutory blindness is evidence showing that your visual acuity or visual field, in the better eye, meets the criteria in A 2 above, provided that those measurements are consistent with the other evidence in your case record. We do not need to document the cause of your blindness” (emphasis added). Also, there is no duration requirement for statutory blindness under Title XVI.”

NADE does not support the concept that statutory blindness can be established for Title XVI claimants (adults or children) based on a loss of visual acuity *without need to document the cause of the blindness*. However, if that provision is based on statute, rather than regulation, and cannot be changed for Title XVI claimants, we believe it should be applicable to Title II claimants as well. Similarly we believe that the 12 month durational requirement, mandated for Title II claimants with visual disorders, but not for Title XVI claimants, should be eliminated for Title II claimants. Those who have paid into the system, often for many years, should not face a more stringent eligibility process when applying for disability benefits than those who have not. Not only is this inherently unfair, it fosters the perception that the individual who has worked and contributed to the nation’s workforce and economy is penalized for having done so.

Thank you for your consideration of our comments.

Sincerely,

*Shari Bratt*

Shari Bratt  
NADE President

Cc: Linda McMahon, Deputy Commissioner for Operations  
Glenn Sklar, Associate Commissioner, Office of Disability Programs  
Lenore Carlson, Associate Commissioner, Office of Disability Determinations  
Jim Julian, Director, Office of Medical Policy  
NADE Board

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***Barnhart, continued from page 4***

But there is still much work to be done to improve the disability process. The Commissioner stated that she knew she could count on the dedicated SSA and DDS employees to work together to accomplish the needed changes to provide better and more accurate service to the disability public.

During a question-and-answer period, the Commissioner was asked for a comment on NADE training conferences that could be taken back to DDS employees and management. The Commissioner responded, “*I don’t know how anyone could read this agenda and think it was just for fun: rewarding, gratifying, challenging all come to mind. I think that conferences like these are vital to ensuring that major issues are addressed, as well as re-energizing our workforce.*”



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October 11, 2005

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

Dear Commissioner:

RE: Revised Medical Criteria for Evaluating Endocrine Disorders,  
Advance Notice of Proposed Rulemaking

On behalf of the National Association of Disability Examiners (NADE) I am writing to offer our comments and suggestions for revising sections 9.00 and 109.00 in the Listing of Impairments; and our suggestions for improving the Social Security and Supplemental Security Income (SSI) disability programs for people with endocrine disorders who would like to work.

NADE is a professional association whose purpose is to promote the art and science of disability evaluation. Our membership includes treating sources and consultants, attorneys, claimant advocates and others interested in the Social Security and SSI disability programs. However, the majority of our members work in the state Disability Determination Service (DDS) agencies, on the "front-line" of the disability evaluation process. It is our extensive program knowledge and "hands on" experience which enables NADE to offer a perspective on disability evaluation that is both realistic and pragmatic.

Our comments and suggestions for updating and revising sections 9.00 and 109.00 in the Listing of Impairments are described below.

9.00

Listing 9.02 (*Thyroid disorders*) and 9.06 (*Hyperfunction of the adrenal cortex*). It would be helpful to indicate, either within the listing, or in the preamble, the types of impairments which could be expected, and the body systems most likely to be involved.

Listing 9.04 (*Hypoparathyroidism with A. Severe recurrent tetany; or B. Recurrent generalized convulsions*). "Recurrent" should be defined.

Listing 9.05 (*Neurohypophyseal insufficiency (diabetes insipidus)* ).  
"Recurrent" should be defined.

Listing 9.08 (*Diabetes mellitus*). "Significant and persistent disorganization of motor function . . .", required by Listing 9.08A, should be more specific and better defined. We would suggest including in the preamble clarifying and descriptive information similar to that found in the preamble to the Musculoskeletal System listings (specifically 1.00 B 2, "*How we define loss of function in these listings*".) We would suggest adding peripheral arterial disease to Listing 9.08, and including in the preamble a discussion of the need to use resting toe systolic blood pressure when the underlying disease results in abnormal arterial calcification or small vessel disease.

We would suggest adding Amputation of one or both lower extremities at or above the tarsal region, with stump complications.  
109.00

Listing 109.02B (*Hypothyroidism*) and:

1. IQ of 70 or less. We question why an IQ is listed in this specific listing when 112.05D addresses this.



Listing 109.03A (*Hyperparathyroidism*) “Repeated” should be defined. We recommend adding “unresponsive to prescribed therapy” as it appears in 109.04A.

Listing 109.04A (*Hypoparathyroidism or Pseudohypoparathyroidism. With severe recurrent tetany or convulsions which are unresponsive to prescribed therapy*). Both “severe” and “recurrent” should be defined.

Listing 109.05 (*Diabetes insipidus, documented by pathologic hypertonic saline or water deprivation test*) and:

A. *Unresponsiveness to Pitressin*. This may be problematic if the medication becomes obsolete or is taken off the market or changed.

D. *Unresponsive hypothalamic thirst center, with chronic or recurrent hypematremia*. “Chronic” and “recurrent” should be defined.

E. *Decreased visual fields attributable to a pituitary lesion*. “Decreased” should be defined.

Listing 109.07 (*Adrenal cortical insufficiency*). “Recent”, “recurrent” and “circulatory collapse” should be defined.

Listing 109.08 (*Juvenile Diabetes Mellitus*) and:

A. *Recent, recurrent hospitalizations with acidosis*. “Recent” and “recurrent” should be defined.

B. *Recent, recurrent episodes of hypoglycemia*. “Recent” and “recurrent” should be defined.

Listing 109.10 (*Pituitary Dwarfism with documented growth hormone deficiency*). We recommend deleting this listing because it is addressed under growth impairments in listing 100.02.

Listing 109.11 (*Adrenogenital Syndrome*) with:

A. *Recent, recurrent salt-losing episodes despite prescribed therapy*. “Recent” and “recurrent” should be defined. We recommend an explanation in the preamble as to what constitutes a “salt-losing episode.”

Listing 109.12 (*Hypoglycemia*). “Recent” and “recurrent” should be defined. We question whether “despite prescribed therapy” needs to be added.

Listing 109.13 (*Gonadal Dysgenesis*). It would be helpful to indicate, either within the listing, or in the preamble, the types of impairments which could be expected, and the body systems most likely to be involved.

### Program Improvements and Return to Work

NADE recognizes, and supports, the need for long-term planning for the disability program and the importance of strengthening and improving programs for people who would like to work.

*Continued on next page*

**Gold Corporate Member**

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Disability Representatives, Inc.**

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Unfortunately, SSA's work incentives have, to date, been only marginally successful. We are hopeful that the demonstration projects described in the Commissioner's proposed regulation to improve the Social Security and SSI disability process will provide insight into ways to improve the programs for people with endocrine disorders who would like to work.

NADE supports early intervention and treatment for disabling conditions, with health insurance coverage and training either before, or in place of, providing cash benefits for those individuals who would like to continue working but who have either lost their job or are unable to continue working due to their disability. We continue to believe that the current five month waiting period for cash benefits and 24 months for Medicare coverage should be reduced or eliminated because of the tremendous hardship this places on disability beneficiaries and their families.

Thank you for providing this opportunity to comment.

Sincerely,

*Shari Bratt*  
Shari Bratt  
NADE President

Cc: Linda McMahon  
Glenn Sklar  
Lenore Carlson  
Jim Julian  
NADE Board

## **NADE Welcomes New Gold Corporate Member - NADR**

The National Association of Disability Representatives (N.A.D.R.) was formed in March of 2000 by 35 professional non-attorney disability representatives who wanted to be part of an organization that would address the issues that faced them and their businesses, and would advance the profession of disability representation.

N.A.D.R.'s Mission is to serve the membership's needs in the areas of professional education and political action; and maintain and enhance the skills of the membership.

As a direct result of N.A.D.R.'s lobbying effort, the Social Security Protection Act of 2004 included provisions to allow fee withholding for qualified non-attorney representatives. N.A.D.R. continues to be a voice in Washington, DC seeking parity for all professional disability representatives and overall improvements in the disability process.

Membership in N.A.D.R. is open to any individual involved in or associated with the practice of Social Security Disability. Membership is composed of past SSA and DDS employees as well as attorneys, social workers, mental health advocates, medical professionals, vocational specialists and legal assistants. If you are considering a career in disability representation, joining this organization should be the first step.

Member benefits include:

- An internet "talk list" providing instant question and answer feedback with other members across the nation
- Reasonably priced national conferences providing excellent learning opportunities and continuing education credits for participants. N.A.D.R.'s next conference will be in Boston on April 2-5, 2006.
- A "members only" form bank and forum with practice tips and important Social Security information
- An active lobbying presence in Washington, DC representing the interests of N.A.D.R. members and the disabled community.
- A national referral service for claimants seeking representation.

For more information, please visit us on the web at [www.nadr.org](http://www.nadr.org) or call 1-800-747-6131.



SOCIAL SECURITY  
Office of Disability and Income Security Programs

OCT 21 2005

Ms. Martha Marshall  
President  
National Association fo Disability Examiners  
2704 Frank Street  
Lansing, MI 48911

Dear Ms. Marshall:

Commissioner Barnhart asked me to thank you for sharing with us the National Association of Disability Examiners (NADE) position paper on elimination of the 24-month waiting period for Medicare benefits coverage for Social Security disability beneficiaries. As you know, Congress has already made exceptions to the 24-month waiting period for individuals with amyotrophic lateral sclerosis (ALS) and End Stage Renal Failure.

The Office of Disability and Income Security Programs is planning a number of demonstration projects which address potential policy and legislative changes. The legislative change supported by NADE in your position paper is addressed by several projects. The projects which test the impact of immediate access to medical benefits through private health care services include:

- Accelerated Benefits
- Mental Health Treatment Study; and
- California HIV/Auto Immune Disorders Demonstration.

These projects are not operational, but we plan to begin enrolling participants in all three projects in 2006. For further information regarding these projects, please visit our website: [www.ssa.gov/disabilityresearch/demos.htm](http://www.ssa.gov/disabilityresearch/demos.htm).

Once we have obtained data and analysis regarding the costs and benefits of providing private health care services to beneficiaries with disabilities within these three projects, SSA will be in a better position to evaluate the merits of the legislative change NADE recommends and its ability to enable our beneficiaries to maximize their economic self-efficiency. For instance, the demonstration project on Accelerated Benefits will allow us to evaluate the long term effects on program costs of eliminating the 24-month waiting period for beneficiaries who are totally disabled for a period of time (e.g. broken back) but are likely to recover if they receive timely and appropriate medical care. If elimination of the 24-month waiting period (along with providing certain employment reports) results in a significant increase in the percentage of persons who fully medically recover and/or return to work, there may be a substantial decrease in both Medicare and DI program costs over the long term. In both the Mental Health Treatment Study and California HIV/Auto-Immune Disorders Demonstration studies, we are exploring the effects of decoupling cash and health insurance benefits. Specifically, we will be evaluating the impact on work of providing private health insurance benefits to title II beneficiaries whose earnings exceed SGA.

Again, thank you for your interest in this issue. We are hopeful our planned demonstrations can help inform future policy decisions in this area.

Sincerely,

A handwritten signature in dark ink, appearing to read "2 10.92" or similar, written over the typed name.

Martin H. Gerry  
Deputy Commissioner  
for Disability and Income Security Programs.

## Conference Coverage

### FIBROMYALGIA

*Presenter: Robert Friedman, M.D.*

*by Susie Toloso, Oklahoma DDS*

An interesting and informative presentation on fibromyalgia was given by Dr. Robert Friedman at the NADE National Conference in Boise, ID.

Fibromyalgia is not a new disease, as back in the 1800's it was referred to as Muscular Rheumatism. Approximately 15 years ago it was a fad disease, often called the "Yuppie Disease" and was over diagnosed much of the time. Fibromyalgia is a syndrome with a history of widespread pain that lasts for over three months' duration and requires involvement of at least 11 of 18 tender trigger points. Symptoms to look for include stiffness lasting from several hours to all day and fatigue to include mental fatigue and sleep disturbances. Pain is increased by cold, wind and loud noise.

### NADE AWARDS

*by Sue Heflin, Awards Chair*

This year's NADE awards were presented at the Awards Luncheon in Boise on September 14, 2005. The prestigious President's Award was presented to the New Mexico Chapter. Their members sponsored 4 children through the angel tree program, donated cash, food and gifts to woman and children who were victims of domestic abuse, donated 438 pounds of food items in a local food drive, and sponsored a Trick or Treat in the DDS for the children who attend the low income day care center across the street. They also hosted luncheons with one of the psychological CE providers and with the local Medicaid Ombudsman. They had a Fall Arts and Crafts Fair and hosted a brunch to welcome the new DDS Administrator. To quote them, they, "had a year packed with worthwhile activities."

Pain components include generalized pain, aching all over with joint pain and weakness, numbness, tingling and poor circulation. Lab testing that may be done will usually be within normal limits. Some associated conditions with fibromyalgia may include Irritable Bowel Syndrome, Irritable Bladder, tension headaches, migraines and depression and Chronic Fatigue Syndrome. Fibromyalgia is not an inflammatory disease even though we use that listing in determining disability.

Fibromyalgia and chronic fatigue syndrome have common feature such as: both are most common in women - ages 20 to 50, fatigue, myalgias, sleeping problems and headaches. There is no identifiable cause, no reproducible physical or lab results and no highly effective therapy.

There are several theories as to the cause of fibromyalgia but none are proven. Several of the theories are infections, immune deficiencies, metabolic disorders and toxic exposure. It has

been studied that it is possibly triggered by infections, Lyme Disease, physical trauma, emotional trauma or medications.

Dr. Friedman concluded with information in regards to treatment. The patient must be involved in their own rehabilitation. A treatment plan may include icing, stretching, limited strengthening and endurance exercises and education. A decrease of stress in the patient's environment may also be beneficial.

### Disease, physical trauma, emotional trauma or medications

Dr. Friedman concluded with information in regards to treatment. The patient must be involved in their own rehabilitation. A treatment plan may include icing, stretching, limited strengthening and endurance exercises and education. A decrease of stress in the patient's environment may also be beneficial. Avoidance of caffeine and tobacco has also been beneficial.

Dr. Steve Salmony of North Carolina received the Charles O. Blalock Award. Steve joined the DDS and NADE in 1995. He has served for several years as a member of the Board of Directors of his local chapter and he has volunteered to serve as a member of various committees at the local, regional, and national level. His most challenging position was to serve as Chair of NADE Long Range Planning Committee from 2000-2002.



*Commissioner Barnhart congratulates Dr. Steve Salmony (r) on receiving the Charles O. Blalock Award.*

The NADE Award went to Evelyn Pate, another member of the Tarheel Association. She was singled out for her vocational expertise and her willingness to assist others, even those outside her own agency. She has recently taken the time to revise and update the vocational handbook used by their DDS staff. Evelyn is also very active in her chapter and well known for her compassion and genuine concern for others.

Missouri's Lecia Mikle received the John Gordon Award for outstanding supervisor. She is always willing to do what she asks of those she supervises in order to serve the claimant. She sometimes does things in unconventional ways to allow for a more relaxed relationship. She is also an active NADE member and has participated extensively at local, state and national levels. She has also served as a regional representative; however, her most challenging position had to be that of 2004 NADE National Training

Conference Coordinator. I think all will agree that the latter event was quite a success!



*Lecia Mikle proudly displays her John Gordon Award*

Paula McNeese is definitely a favorite for the Frank Barclay Award. She is currently Director of Program Development in Texas. In that position she trains all incoming examiners, temporary employees, support staff, medical consultants, and case review specialists. She also provides ongoing agency-wide training as the need arises. She has also been responsible for eDib preparation and implementation and training. It is hard to imagine how she finds time to sleep and eat in addition to participating in local TADE activities noted!

David Lovingood of Alabama, a former Southeast Regional Director, was named the recipient of the Lewis Buckingham Award. He has also served as the Regional President twice and has served in various capacities at the local, regional and national levels. He served in the military for over 20 years and retired from the U.S. Army in March 2005.



*Alabama DDS had two winners! Tommy Warren (left) and David Lovingood were recognized for service to NADE and recipients of national awards. Warren received the Earl B. Thomas Award and Lovingood was honored with the Lewis Buckingham Award.*

Jaime Schneble of Kentucky was selected the Rookie of the Year. This examiner began her tenure as a trainee in 9/03 and has done an extraordinary job for both the DDS and her chapter. She works on all types of cases and is not only caught up every day but also frequently volunteers to help others! She is obviously well respected already by the staff at all levels in her agency for her knowledge and skill. She has received some high praise to date and I'm sure we can expect to hear more about her in the future.

Niki Wigington won the Director's Award. She began work at the Oklahoma DDS four years ago as a typist clerk and now works as an administrative technician in the hearing unit. She even goes above and beyond the call of duty and volunteers to cover other units when their module support staff is out of the office. She is her chapter's treasurer

after serving the last two years as secretary plus she has served on other local committees and as the regional NDPW committee representative.

Tommy Warren, Director of the Alabama DDS, received the Earl B. Thomas Award. He has been employed with the DDS since 1971 and has been the director for the last 11 years. During that time he also served as President of the National Council of Disability Determination Directors (NCDDD). Tommy worked with SSA on prototype and eDib and has always been a strong supporter of NADE.

I hope that you will join me in congratulating all of our award winners. We are so fortunate to have so many hard working and talented NADE members who are nominated for these awards that it is truly an honor to win!



### **New To NADE's Certification Honor Roll:**

**Joseph Pacheco      California**



## Continued Conference Coverage

### CDI –Mission Fraud

*Speaker – Patrick O' Carroll,  
Inspector General*

*by Bev Kontola, Minnesota DDS*

Patrick P. O'Carroll, Jr., Inspector General for the Social Security Administration spoke to NADE National Conference Attendees on Tuesday, September 13, 2005. He was appointed as SSA's third Inspector General on November 24, 2004. He served in a number of high-level positions at the Office of the Inspector General (OIG) and also had 24 years of experience in the United States Secret Service.

The OIG was formed ten years ago and has over 600 employees. One of its programs is the Cooperative Disability Investigation (CDI) program. The program, a joint effort of the OIG, SSA, State DDSs and state or local law enforcement personnel, consists of 18 CDI units in 17 states. Its mission is to obtain evidence sufficient to identify and resolve issues of fraud and abuse related to initial and continuing disability claims. CDI units investigate individual disability claims and identify lawyers, doctors, translators or others who facilitate disability fraud. In the first half of 2005, the investigations resulted in over \$55 million in SSA program savings and more than \$36 million in savings to non-SSA programs such as Medicaid. NADE has acknowledged the success of the CDI program, noting that it represents an effective use of resources and recommended that the program be expanded to all 50 states.

Mr. O'Carroll regaled attendees with a number of video "clues" of supposedly-disabled claimants walking into consultative exams with extreme difficulty, only to be caught later on tape running, working and even being thrown about in a wrestling ring! He emphasized that most claimants are honest and only a small percentage intend to defraud the system.

U.S. Senator Chuck Grassley, Chair of the Senate Finance Committee, has requested that a special audit be performed on Social Security disability cases. This audit and analysis will be completed soon and will provide Congress with needed information for policy decisions.

If a DDS employee suspects a fraudulent claim, they should follow instructions on the SSA Program Operations Manual System (POMS) GN 04111.035, *How the DDS Reports Program Violations*. Taking questions from the audience on fraud and related OIG issues, Mr. O'Carroll responded to an inquiry about threats made to DDS staff.



*Inspector General Patrick O'Carroll  
stopped to visit with NADE President  
Marty Marshall.*

He assured the audience that any threats made to DDS employees are taken seriously and there is zero tolerance for such activity.

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### eDIB from the Trenches

*by Harry Herbert, Idaho DDS*

A panel presentation at the National Convention in Boise attempted to provide information from the front lines on the transition to electronic case processing. Panel members were from state agencies and represented the three major software platforms used by the DDSs. They represented both centralized and decentralized states. Members were Shamoon Alli, WA; Nell Bailey, NC; Mark Bernskoetter, MO; Matthew DeJonge, OK; and Peter Fox, OR. The panel moderator was Harry Herbert of the Idaho DDS. All panelists were either disability examiners or front line supervisors of examiners.

The purpose of the panel was to discuss eDIB experiences. A major secondary purpose was to stimulate discussion with the audience on "how do you do that." The panel accomplished both objectives.

Peter Fox from Oregon reported that the introduction of the Versa version of software that is compatible with

a totally paperless process in his state smoothed out a lot of problems. Mark Bernskoetter from Missouri mentioned a recurring theme. The success that medical consultants have with the new process is related to their preexisting comfort level dealing with computers. There were a number of comments that some Medical Consultants are doing a great job in the new environment. Matthew from Oklahoma was a relatively new examiner and had only worked with electronic claims. This seemed to be the case in a number of states. New trainees are being exposed only to electronic claims.

Comments from the panel and audience seemed to reflect that this process is very successful. The trainees were not discouraged and were achieving acceptable results. Nell Bailey reported on North Carolina's comparatively long experience working with eDIB. Their support staff provides considerable assistance to the examiners but the responsibility for insuring that the electronic and

*Continued on next page*



## **Medical Consultants Discuss Issues of Concern**

*by Frank G. Lahman, Ph.D.  
Psychologist/Medical Consultant  
President, Oregon Association of  
Disability Employees*

This break-out session was attended by medical consultants, representatives of DDS and SSA.

One issue dominated the meeting: The newly proposed, yet-to-be-defined qualifications for continued or future employment of Medical Consultants. Concern was expressed about the potential conflict between the Commissioner's oft-repeated pledges that no current DDS or SSA employee will be adversely affected by the redesign of the SSA disability determination process and the upcoming qualifications.

In the Commissioner's September 2003 Broadcast to all SSA and DDS employees containing her testimony before the House Ways and Means Committee, she said, "I also decided...to ensure that no SSA employee would be adversely affected by my approach. My reference to SSA employees includes state Disability Determination Service (DDS) employees and Administrative

Law Judges (ALJs). This has great potential for invalidation by the more recent statement included in the NPRM of 7/27/05, "Our proposed regulations also provide that we will not reimburse State agencies for the costs associated with work performed on our behalf by experts employed by, or under contract with, the State agencies who do not meet our qualification standards."

It was the earnest desire of those participating in this session that the committee from the Institute of Medicine (IOM) which is formulating these requirements understands the heterogeneity of states' needs and options for hiring and using Medical Consultants. It is also expected that the new requirements be consistent with the Commissioner's pledge to not adversely impact currently employed Medical Consultants.

Relevant position statements addressing this issue by the National Council of Disability Determination Directors (NCDDD), National Association of Disability Examiners (NADE), and other units of affected medical consultants have been directed to the Commissioner and should be consulted to provide important context.

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*Trenches from page 14*

paper file match at the end of the line is the examiners. Nell added that North Carolina is testing the use of dual monitors by examiners and medical consultants and preliminary reports are favorable. Shamoon Alli from Washington stressed the need to watch "to do" lists in an electronic environment. A good exchange of how to perform different tasks in eDIB took place between panel members and the audience. Several members of the audience offered excellent information that others commented was very helpful.

The panel truly demonstrated one of the great benefits of our national training conferences. They are a very valuable forum for those people dealing with the day to day problems in our working environment to exchange practical and useful information.

*Editor's Note: SSA has been making the news in trade magazines. Network World applauds the SSA move toward an electronic folder and highlights the benefits that will be achieved with this system.*

*To read their coverage see: <http://www.networkworld.com/news/2005/091205-ssa.html>*



**Letters to the Editor  
can be sent to:  
Donna Hilton  
Publications Director  
1117 Sunshine Drive  
Aurora, MO 65605**

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Grants should  
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**Barbara Styles  
639 Crosscreek Trail  
Pelham AL 35124**



*Continued Conference Coverage*

## Compassion Fatigue

*Presenter: Judy Parker-Frederick,  
RN, MS*

*by Mark Bernskoetter, Missouri DDS*

Judy Parker-Frederick has a Masters degree with emphasis on grief and loss. She is a Thanatologist – one who studies death and the psychological processes of coping with death.

She began her presentation with brief descriptions of several scenes from the aftermath of Hurricane Katrina that many of us have seen or heard about through the media or by word of mouth – the despair, the need, the heroism, the caring and concern from people around the nation. She defined compassion as the deep awareness of the suffering of another coupled with the wish to relieve it. When we feel compassionate, for a time, we feel a little less powerless.

The power of the big traumas like 9/11 and Katrina, is seductive, they are the mess of life, the stories that everyone remembers. What about the little stories that never makes the news? What about all those stories that end up on our desk? The stock broker, the student, the nurse, the child, the average person involved in an accident, or diagnosed with cancer, or in need of heart surgery. Those cases represent many stories of tragedy that bring that person into your life. We may hide behind medical diagnoses, theo-

ries, and acerbic humor to avoid the deep awareness of the trauma.

Compassion fatigue shuts down our openness to the suffering and needs of others. When we are overloaded for the requests for aid and overwhelmed by the sheer numbers of those in need, we become jaded over weeks, months and years of new needs being brought to our attention. It begins to blunt all our life – nibbling away at life's joy, not sleeping as well, easily angered, feeling distanced and alone, and avoiding contact with family, friends and even things we love to do. This is when we need others the most. Hopelessness insinuates itself.

Stress adaptation response – fight, flight, or freeze. Every one of us is a success story of our ancestors. When faced with a stressor, we naturally react – heart rate, blood pressure, respiration increase, hyper alert scanning of the environment (“I can’t keep my mind on anything” is actually a sign of hyper alert state so that everything catches your attention), “awfulizing,” increased blood flow to muscles, fatty acids, glucose, fibrinogen (fibers), adrenalin. Digestion is put off to later, so stomach upset is symptomatic.

When facing danger, don’t get caught frozen in the headlights. It is in

action that we find the best ways of dealing with the situation. We have choices. While you may not be able to heal all the hurts or solve all the problems, while you may not be able to change someone’s life, you can change that day for them.

Stress is contagious, but so it chilling out. Surround yourself with safe situations, familiar locales, people, or routines. Warming the skin is therapeutic: a 20 minute warm bath can have the same effect as a dose of valium. Drink plenty of fluids. Eat small, frequent, nutritious meals; comfort foods help. Breathe slow, deep, quiet, and regular. These tell our limbic system that things are OK. What do you do to balance your life? What do you do for fun and enjoyment? Not something you do when you get around to it, but part of the breath of life. Sitting down and telling our stories will help us to cope and understand and feel again. Living in each moment is good for our psyche. Being present with pain allows us to find joys, too. If we expect only joy, we will always be disappointed. Finally, once you have done what you can do, let it go, and trust that there will be others who can and will help where you left off, just as you will find another individual in need of your help.

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## Electronic SSA Spans the Nation

by Paul Absalon, Nebraska DDS

In a presentation at the NADE National Training Conference in Boise, Diana Andrews and Laura Train of the Office of Disability Systems provided information regarding where we are now, how we got here and where we are going with eDIB and DMA (Document Management Architecture).

Presently, 10 million claims have been captured through EDCS; 280,000 applications have been processed through EDCS via the internet, and all 54 DDSs have interfaced some part of EDCS. At this time, 100% of the hearings units use EDCS. DMA has over 14 million documents in its repository, with the potential of being the largest database in the world. IDA is the Independence Day Assessment designed to establish a business process and a review of DMA to make sure the actual documents go into the repository. Four states are currently IDA certified (Mississippi, Illinois, Hawaii, and Nevada) with nine other states soon to become certified. All DDS sites are expected to be IDA certified by the end of 2006.

Ms. Andrews discussed the National Scanning Contract, use of dual monitors, LAN Caching to keep parts of the process local, eForms, and an eDIB Help Desk. Disability Systems is also in the process of reviewing new programs and software that can be adjusted for our systems to improve all aspects of the DMA process. DMA has, to date, processed 25,000 faxed documents and 46 states are using EME (Electronic Medical Evidence).

Ms. Train assures us that it is getting easier and the process is continuing to be improved. The first tip for success was to become a DMA expert or find one. Other tips include: use the system to its fullest, let the appropriate person know if there are problems, share your best practices, know your business process, and use resources on the web. The electronic process will reduce keystrokes,

there will be no more looking for lost folders, folder storage is eliminated, and reconstruction of cases disappears. EDCS builds in checks for completeness and DMA is implementing enhancements to bookmarks and preferences taking into consideration the ability to save individual preferences for annotations, color, size, shape, etc, and the ability to input other employees' preferences. By selecting the help button located in the DMA viewer (which looks like a question mark), users can easily access release notes, links to DMA newsletter, and training guides. The DMA Best Practice Website which contains short

training videos, PowerPoints and desk aids on a variety topics is located at:

[http://co.ba.ssa.gov/dcs/odssis/edib/dma/menu\\_best\\_practices.asp](http://co.ba.ssa.gov/dcs/odssis/edib/dma/menu_best_practices.asp).

All MER (Medical Evidence of Record) is expected to be electronic within 10 years with 1 million sheets per day being transmitted. We will be the largest repository of electronic MER in the world. More information is available at the National eDIB website: <http://co.ba.ssa.gov/disability/odp/aedib.html> and ODSSIS eDIB website: <http://co.ba.ssa.gov/dcs/odssis/edib/index.htm>



*Laura Train and Diana Andrews provided updates on the new electronic process.*



*SSA Deputy Chief Strategic Officer Susan Kennedy takes a moment after her presentation to visit with Terri Klubertanz and Christa Royer.*

*Continued Conference Coverage*



*Patch Adams MD*

Patch Adams, MD was a keynote speaker at the NADE national conference in Boise Idaho. Dr. Adams, along with the assistance of a local clowning group, provided a lengthy and insightful discussion on healthcare delivery.

Dr. Adams is a political activist who has used his many talents and experience as both clown and physician to try and bring about peaceful change in the world. His philosophical approach to life is focused on joy and love, and his actions exemplify this philosophy. He has traveled the world and seen humanity at every point along the curve. In addition to being a powerful orator, he is a surprisingly good listener. Patch is compassionate, friendly and approachable (if you are ready to be hugged).

Dr. Adams has been a physician for 35 years and has never accepted payment or third party reimbursement for his services. He and several other physicians opened the Gesundheit Institute in West Virginia, after graduation from medical school. They treated 15,000 guests over the first 12 years at no initial charge. Guests were not allowed to pay for services or donate to the hospital for 6 months after receiving care.

## **Patch Adams: Social Activist, Physician, and Humorist Promotes Peace and Love Through Healthcare**

*by Peter D Fox, Oregon DDS*

Additionally, Dr. Adams and his companions did not carry malpractice insurance as part of their agreement with their patients. They intended no harm and took care of any harm inadvertently done to patients.

When discussing delivery of care, Patch provided examples of his own methods. Dr. Adams firmly believes that insulation between doctor and patient leads to distrust and fear and inevitably to restriction on ability to provide care. Even the most highly trained professional never knows in advance the consequences of care. When initially evaluating a new patient he would conduct a lengthy (4 hour) interview with them. He insisted on house calls when possible in order to learn more about who he was treating. To him healthcare doesn't start and end with acute illness but instead extends to the whole person, their family, community and even their society. The institute practices integrated healthcare, employing many modalities to treat people including art, agriculture, as well as methods from a myriad of different medical specialties.

While most of his discussion was focused on the positives he did return to the fact that, in 40 years, nothing positive has been said about the health care delivery in the United States. When polled during his presentation, many attendees were dissatisfied with their access to care and delivery. Not surprisingly, Dr. Adams had little positive to say about the many insurance programs representing the public. Poor delivery has directly impacted standard of care and prevented adequate treatment or follow up.

Patch continues to strive for unencumbered healthcare; he sponsors numerous medical students, trips around the world and fights everyday for foundation of his dream. More information on Patch, the Gesundheit Institute or ways to improve delivery of health care is all available through his network, in his books or on his website [www.patchadams.org/home.htm](http://www.patchadams.org/home.htm). He also answers any correspondence sent to him personally. He has never used email so be prepared for a long-hand reply.

***Patch's Principle of Medicine:  
"Do no harm."  
His petition: "Please give your life  
to peace, justice, and care."***

The address is:  
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## Highlights of the Annual Membership Meeting

by Juanita Boston, NADE Secretary

The Annual Membership meeting was held during the National Training Conference in Boise. Reports were presented by all officers, regional directors, appointed directors, and committee chairmen.

A change in procedure allowed the heads of committees, which have competitive events, to make those presentations during the membership meeting.

**Membership Awards** were presented by Debi Gardiner, Membership Director:

Large Chapter Awards

First Place Idaho

Second Place North Carolina

Medium Chapter Awards

First Place South Carolina

Second Place West Virginia/Clarksburg

Small Chapter Awards

First Place Tennessee

Second Place California-South

**Newsletter Awards** were presented by Donna Hilton, Publications Director:

### Large Chapters

First Place Missouri MADE in Missouri

Second Place North Carolina THADE E-News

### Medium Chapters

First Place Oregon Pacific Wave

Second Place New Hampshire Granite State Voice

### Small Chapter:

First Place Tennessee Music City Notes

**Photo Contest Awards** were also presented by Donna Hilton.

First Place - Oklahoma "Walk America 2005"

Tie for Second Place - Illinois Chapter **Thanksgiving Food Drive** and  
Mimi Wirtanen **NADE Leaders on the Hill**

Ruth Trent presented the **National Disability Professionals Week Awards:**

**Theme Winner** Lora Coffman, Missouri

### Large Chapter

First Place North Carolina

Second Place Tie Oklahoma and New York-East

### Medium Chapter

First Place Nebraska

Second Place Shreveport, Louisiana


### Small Chapter

First Place South Dakota

Second Place Derby City, Kentucky

Paula Sawyer, Non Dues Revenue Chairperson stated the Committee worked on five money making events this year. These events are the, the Annual Silent Auction, sale of NADE items by mail and here at the conference, and the first ever National Fundraiser for NADE and NADE Talent Show held here in Boise. The total money from these events was \$5,000.00. The committee is to be commended for an outstanding year.

*Continued on next page*



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## ***Highlights continued***

Joanna Brooks presented the **Organ Donor Week Participant Awards**. North Carolina and Michigan were recognized for their participation.

The winners were:

**Large Chapter**                      LADE Shreveport, Louisiana

**Small Chapter**                      ESADE New York

### **Actions of the 2004-2005 NADE Board and 2005 Conference Membership Meeting included:**

**1. Two Position papers** were written on (1) The Waiting Period, and (2) Medicare. These were shared with SSA and other interested parties.

**2. The Definition of Disability Workgroup** will continue for another year. The incoming president will be seeking new members and a chairperson for this committee.

**3. NADE Mentoring guidelines** were prepared by Debi Gardiner and Terri Klubertanz.

**4. Retirees Committee** - The Old Board established a Retirees Ad Hoc Committee.

**5. NADE Incorporation** - Due to a lapse in incorporation, a study was done to determine the least expensive way to re-establish NADE as an incorporated organization. NADE will be incorporated in Texas with Dean Crawford as the designated agent.

**6. Recognition of New Chapter**—South Carolina Association of Disability Examiners (SCADE) Members of the South Carolina Chapter accepted the plaque for their new chapter.

**7. Katrina Relief Fund** - NADE will be donating the profits from the Talent Show and additional money donated by the chapters to the SSA Federal Employee Assistance and Education Fund.

**8. Change in By-Laws** – The By-laws were changed throughout the document to reflect the name change of Delegate Assembly to Membership Meeting.

**9. NPRMs on visual and endocrine systems were announced coming up.** NADE members were urged to contact NADE leaders with input as NADE's official letters on these issues would soon be drafted..

### **10. 2006 Conference Update**

Regional Director Georgina Huskey showed a video and presented the following information:

The conference will be held September 16-21, 2006 at the Bahia Hotel and Resort in San Diego, California.

The room rate will be \$110.00. The theme is "Surfing the Wave of Change". Registration fee is still under discussion and information will be sent out electronically.

### **11. 2007 Conference Update**

Joanna Brooks of the South Dakota chapter gave the following update:

The conference will be held September 15-20, 2007 at the Holiday Inn-Downtown Sioux Falls, SD.

The room rate \$79.00. Concierge level is \$89.00.

### **12. Elections:**

In an uncontested race for all offices, the general membership elected the following NADE Officers for 2005-2006:

President Elect—Charles Schimmels, Oklahoma

Secretary—Juanita G. Boston, North Carolina

Treasurer—Steven Segall, Washington

**13. Passing of the Gavel** – Marty Marshall passed the NADE leadership on to Shari Bratt (NE). She assumed the duties as NADE President as the conclusion of the National Training Conference.





## The Eye Doctor's Chart

Presentation by Dr. Garry Griswold, OD

by Barbara Styles, Alabama DDS



*Dr. Garry Griswold describes information in eye exam reports.*

Dr. Griswold does consultative work for the Idaho Commission for the Blind and Visually Impaired. He presented a very interesting presentation about the information typically found on a medical report received from either optometrists or ophthalmologists.

The most common information found in medical evidence of record pertaining to vision is:

- (1) *Visual acuities* for both far and near vision, presented both with and without vision correction – this information is basically what the patient is seeing. Dr. Griswold explained that “20/20 vision” actually means that the patient is seeing a “20” size letter at 20 feet. This is considered normal vision. For near vision, a visual acuity of 20/50 is the size of newsprint. 20/200 vision or worse (best corrected in the better eye) indicates legal blindness.
- (2) *Visual fields* – this is a measurement of peripheral vision. Confrontation testing is a gross measurement of peripheral vision using the fingers to map the vision. There are also automated ways to check visual fields, i.e. Humphrey, Dicon, etc. but all are based on the Goldmann perimeter.
- (3) *Papillary responses* – this is a measurement of how pupils react to light. A normal reaction is usually recorded as “pupils equally round and reactive to light and accommodation.” The eye doctor will note what happens if there is an abnormal reaction.
- (4) *Eye movements and muscle balance* – if recorded as “smooth and full”, that is considered normal. Abnormal responses may include nystagmus or restricted movement in either eye.
- (5) *Intraocular pressures* – this is pressure recorded inside the eye, measured by tonometry. The types of tonometry are applanation (Goldmann), which touches the eye; or non-contact (air puff). A normal intra-ocular pressure is in the range of 10-21mm Hg. This test is an indicator for glaucoma.
- (6) *Refraction* – this determination of refractive error is the actual eye glass or contact lens prescription. It is calculated in diopters, a measure of lens power. Optometrists and ophthalmologists may record refractive correction differently. Optometrists (OD’s) record in eyeglass lens power and ophthalmologists (MD’s) record in eye power form.
- (7) *Binocular vision determination* – this is a measurement of the ability of the eyes to track together. Common terms are esotropia (eyes turn in) or exotropia (eyes turn out).
- (8) *Slit lamp exam/external eye exam* – this test is so the eye doctor can look at the external eye and front of the inside of the eye back to behind the iris. The doctor is looking for deformities or abnormalities in the lids, the cornea, the chamber between the cornea and iris (anterior chamber), the iris and the lens.
- (9) *Dilated fundus exam* – a test to view the internal structures of the eye behind the lens. This part of the examination may show the eye doctor potential problems with the optic nerve; reduction of the size of eye vessels (may be indicative of hypertension or other problems); macular degeneration or hemorrhages; and other abnormalities in the vitreous or peripheral retina.
- (10) *Color Perception* – this is not always tested. Four to eight percent of the male population and 1 percent of the female population has abnormal color perception. “Color blind” is an incorrect term, as most people with abnormal color perception have a red/green error. True color blindness (achromatopsia = no color perception) is quite uncommon.

Dr. Griswold went on to discuss with the participants various aspects of visual disability. Most often, to be considered visually impaired, one would have to have acuities of 20/70 or worse. When a patient is “functionally blind” he/she cannot perform normal daily tasks. Dr. Griswold indicated that as disability adjudicators, we should make sure our medical information is up-to-date and

*Continued to next page*

*Eye Doc, continued*

reflects any current treatment. Malin-gering during testing is sometimes difficult to determine. Also, very young patients are not always good at observation and answers.

Dr. Griswold's interesting presentation was quite informative. He encouraged us to always contact the eye care professionals if there were any conflicts or questions about the patient's findings. Most doctors are quite willing to explain why and how they got their results.

Dr Griswold can be contacted at:  
[ggriswold@icbvi.state.id.us](mailto:ggriswold@icbvi.state.id.us) or at  
[blinddoc1@juno.com](mailto:blinddoc1@juno.com).

## Regional Conference Updates

### Northeast and Mid-Atlantic Regions Shine at the Quad

*by Debi Chowdhury, ESADE*

The glimmer of a Quad Regional Training Conference came to life in Raleigh, North Carolina during the week of April 17-20th. It began to grow in our thoughts at the previous year's Tri-Regional in Louisville, KY. It grew by leaps and bounds and, when all was said and done, there were over two hundred thirty five registered. Almost every state was represented.

Awards were presented to recipients at the Award Dinner, with Commissioner Barnhart congratulating all the winners along with the regional director and the regional president.

Northeast winners were:

Chapter - NADE in New Hampshire (conceived in 1999 and has grown four times its original size and in activities with fundraisers to pay dues for every member.)

Professional Award - Rosa Perez from PRADE who is a QA supervisor and member of NADE since 1981.

Support Staff Award - Maria Torres from PRADE has been a member of NADE since 1983.

## NADE Welcomes Its Newest Chapter, The South Carolina Association of Disability Examiners (SCADE).



*NADE welcomed South Carolina as its newest chapter (names are from left: Margaret Yeats, Diane Hare, Tom Paige – DDS Director, Donna Blanchard, and Cindia Kirby).*

The membership award was given to 1st place-Maine, and the other three chapters were recognized for contributions: Vermont (GMADE), NADE in New Hampshire, Buffalo NY (WYNADE).

Mid-Atlantic winners were:

Chapter - Clarksburg, West Virginia, (WVADE) youngest of the region and the greatest increase of membership at the quad regional conference.

Support Staff Award - Teresa Daniels  
Supervisor's Award - Dr. George Albright III, Chief Medical Consultant for the Maryland DDS and a longtime member of NADE.

Professional Award - Stacey Miranda, MARADE member since 1981.

A special award was given to Anne Graham, longtime NADE member, officer, who recently retired from SSA and had been a member of Maryland DDS, and who is still very active in our organization.

Next year's Training Conference will again be a quad meeting. It will be hosted by the Mid-Atlantic Region and held at the Sheraton Hotel, Virginia Beach, VA. Dates are May 16-18th,

2006 and the room rate will be \$101. Regions attending will be Northeast, Southeast, and Southwest.

### 'THERE'S MORE TO LIFE THAN E-DIB'

*by Marcia Shantz, Michigan DDS*

"There's More to Life Than E-Dib" was the theme of Michigan's Annual State Training Conference. This year the Michigan Association of Disability Examiners' Lansing Sub-Chapter hosted the conference on August 5<sup>th</sup> in Lansing, MI. (NADE is MADE in Michigan!) All four Michigan DDS offices were well represented among conference attendees. Those present were welcomed by State Chapter President, Mike O'Connor, and Central Service Area's Administrator, Laurel Baltimore. In addition, Lansing's Sub-Chapter President, Mimi Wirtenan, promised the day's agenda to be an excellent training opportunity without mention of E-DIB!

First on the agenda was Janet Strobe, Michigan's DDS director. Officially the Director of Family Support Services for the Department of Human Services, Ms. Strobe has been serving as the interim Director of Children's Services for DHS.

*continued on next page*

Just like her work has been increased, she recognized the impact of increasing case loads throughout the entire agency.

In her address, Janet Strobe outlined how impressed she was with the DDS teamwork involved in processing a disability case from start to finish. It has been through this spirit that examiners have been able to maintain or even reduce backlog sizes. She commended all examiners and DDS staff for providing a real life example of her own personal motto, "Together we can!"

Attendees of Michigan's Annual State Training Conference were fortunate to hear some outstanding speakers on a variety of topics. Speaker Matthew J. Habecker provided a very educational presentation on orthotics and prosthetics. By viewing actual devices, fascinated listeners saw first hand the painstaking customization involved in casting, modifying, fabricating, fitting and then delivering orthotic and prosthetic devices. All were enlightened as to how this artistic labor transforms the lives of patients.

Additionally, speaker David "Tom" Johns, Senior Vocational Policy Analyst, gave a very informative presentation on vocational analysis. For many this was a welcomed refresher training. The consensus was that Mr. Johns was an excellent, entertaining educator.

MADE was proud to have their very own member, NADE President, Marty Marshall, present at this year's annual training conference. She gave an informative presentation regarding the activities of NADE and benefits of NADE.

The Michigan chapter showed it's commitment to NADE's mission to educate on the importance of life giving organ donation by inviting Frank X. Bodino, transplant recipient, and Jacob "Jack" Locicero, donor father, to travel from New Jersey to Michigan to tell their stories. Frank was born and raised in the state of New Jersey. In the winter of 1995, after suffering his sixth heart attack, Frank was diagnosed with severe

cardiomyopathy. Frank spent the next eight months in the hospital attached to an assist device which made it impossible to venture farther than sixteen feet from an electrical outlet. On the tenth day of August, 1996, a day he remembers like yesterday, he received his "Gift of Life." It was his heart transplant, which was performed at Columbia Presbyterian Medical Center in New York City. As a result of his transplant, Frank was able to enjoy the three proudest moments of his life to date. He attended the college graduations of each of his three children.

Jack, also from New Jersey, had an accomplished life, serving in the Korean War, teaching industrial arts and electronics 28 years until his retirement in 1990, and raising two beautiful daughters, Amy and Carrie, with his wife of 40 years, Arlene. Jack shared how Amy, his first child, gave the "Gift of Life" after being the sixth fatality of the Long Island Rail Road Massacre in 1993. He now actively promotes organ and tissue donation through radio, television interviews, newspaper articles and presentations at conferences and public schools. A&E aired a television production of "Minute by Minute" with the Lociceros and Amy's heart recipient.

While not a dry eye remained in the audience, these two gentlemen accomplished their mission. The exhibit by

Michigan Gift of Life was rushed by those wanting to sign the national organ donor registry.

The day ended with the presentation by author and motivational speaker, C. Leslie Charles, "Why Is Everyone So Cranky?" Well, we all knew why, but none the less, as promised, it wasn't mentioned. Instead, Leslie Charles, with her down-to-earth delivery, provided audience members with practical approaches to everyday problems, essentials for creating a generally cranky-free life. Anyone can take her brief Cranky Quiz to determine a personal CQ (Crankiness Quotient) at [www.WhyIsEveryoneSoCranky.com](http://www.WhyIsEveryoneSoCranky.com).

MADE, continually an active chapter, displayed their 2005 Great Lakes Regional Awards at the awards luncheon. Michigan won the Chapter Award, the Administrator Award and the Membership Increase Award. Also, President Mike O'Connor presented several subchapter members with the MADE Extra Mile Award for their contributions to MADE.

Overall, everyone in attendance had a most informative and positive experience. As for next year, Michigan will be hosting the Great Lakes Regional Training Conference in April 2006 in lieu of a state conference. See you in Kalamazoo!



*Michigan members display awards at the 2005 Great Lakes Regional Training Conference: (from left) Claudette Bensur, Mimi Wirtanen, Linda Largo, Marcia Shantz, Marty Marshall, Theresa Furget, Sharon Brady, and Mike O'Connor.*

*For more information visit these links of interest:*

*Transplant Speakers International: <http://www.transplant-speakers.org/> and Gift of Life: <http://www.giftoflifemichigan.org/>.*

## **Elimination of the Twenty-Four Month Medicare Waiting Period for Social Security Disability Beneficiaries**

### ***A NADE Position Paper***

Most Social Security disability beneficiaries have serious health problems, low incomes and limited access to health insurance. Many cannot afford private health insurance due to the high cost secondary to their pre-existing health conditions. Members of the National Association of Disability Examiners (NADE) are deeply concerned about the hardship the 24 month Medicare waiting period creates for these disabled individuals, and their families, at one of the most vulnerable periods of their lives.

NADE is a professional association whose mission is to advance the art and science of disability evaluation. Although our membership includes treating sources and consultants, attorneys, claimant advocates and others interested in the Social Security and Supplemental Security Income (SSI) disability programs, the majority of our members work in the state Disability Determination Service (DDS) agencies, on the “front-line” of the disability evaluation process and are directly involved in processing claims for Social Security and SSI disability benefits. The diversity of our membership, our extensive program knowledge, our “hands-on” experience and our ongoing communication with both claimants and beneficiaries enables NADE to offer a unique perspective on those disability programs.

In 1972, Congress passed Social Security legislation extending Medicare coverage to persons who had been receiving disability cash benefits for 24 consecutive months. Congress is to be commended for providing these health care benefits for the disabled American population. The original purpose of the Medicare waiting period was to “help keep program costs within reasonable bounds, avoid overlapping private insurance protection and provide assurance that the protection will be available to those whose disabilities have proven to be severe and long lasting.”

In the original 1972 legislation there was one exception to the 24 month Medicare waiting period. Individuals with chronic renal disease would only have to wait three months before receiving Medicare benefits. In 2000, Congress passed legislation, implemented in 2001, that eliminated the Medicare waiting period for those individuals with amyotrophic lateral sclerosis (ALS), commonly known as Lou Gehrig’s disease. In both of these situations, it was felt that the health of the affected individuals warranted more timely access to Medicare coverage.

Currently nearly six million disabled individuals receive Medicare benefits, and Medicare plays a vital role in ensuring that these individuals have access to appropriate and affordable health care. **NADE believes that requiring some disabled individuals to serve a waiting period before receiving health care benefits and not requiring others to do so is fundamentally unfair and causes a tremendous hardship for individuals with disabilities at one of the most vulnerable periods of their lives.**

All Title II Social Security disability beneficiaries, except for the two groups mentioned above, are required to serve a 24 month waiting period before becoming eligible for Medicare benefits. The Medicare waiting period begins with the first month of receiving Social Security disability cash benefits which is five full months after the onset of a disability. This means that the majority of Social Security disability beneficiaries actually wait *twenty-nine months* after the onset of their disability before becoming eligible for Medicare health insurance benefits.

The majority of Social Security disability beneficiaries have impairments that are severe and long lasting. Currently fewer than one percent of Social Security disability beneficiaries have their benefits terminated each year. Another four percent die during the Medicare waiting period. Many beneficiaries suffer irrevocable physical and mental deterioration while waiting for Medicare coverage and needed health care services. Early intervention and provision of needed health care services as soon as possible after the onset of disability, and at a time when the individual needs it most, could improve both these statistics and the quality of life for individuals with disabilities. **NADE supports the elimination of, or at the very least a reduction of, the 24 month waiting period for Medicare benefits for all Title II disability beneficiaries.** *This change is needed to ensure fundamental fairness in the program and equity to all Social Security disability beneficiaries.*

Eliminating, or reducing, the 24 month Medicare waiting period for Social Security disability beneficiaries would address the insurance needs of a high-risk, high-need population and provide financial relief and access to health care services at a time when health care needs are especially pressing and few alternatives exist.

Social Security beneficiaries in the Medicare waiting period face enormous problems. Research conducted by the Commonwealth Fund, in conjunction with the Henry J. Kaiser Family Foundation and the Christopher Reeve Paralysis Foundation, found that Social Security disability beneficiaries reported “skipping medications, putting off needed care, feeling depressed and anxious about the future, and believing they were not in control of their own lives” during the twenty-four month Medicare waiting period.

Although some Social Security disability beneficiaries may initially be found eligible for SSI (thereby receiving Medicaid benefits), many lose that health care coverage when they complete their five-month waiting period and begin receiving Social Security disability cash benefits. Thus many disability beneficiaries are without any health insurance for at least some portion of their 24 month Medicare waiting period. Without health care coverage, individuals’ health conditions cannot improve, nor can they return to work, participate in their communities or stop depending on family members and friends for their basic needs. Beneficiaries need better access to health services before they can consider working again. Many individuals with disabilities might return to work if afforded access to necessary health care and related services.

NADE members, who work on the “front-line” of the disability program, have first-hand experience with the hardships that the 24 month Medicare waiting period places on disabled beneficiaries. During continuing disability reviews NADE members all too often see individuals whose conditions, without proper health care coverage, have markedly deteriorated and who are significantly worse than when they were initially awarded disability benefits. The financial and emotional toll this has taken on the disabled beneficiary and their families is disheartening. Many individuals who could have been cured and/or found to be no longer disabled continue to be disabled due to the lack of access to needed health care services during the early stages of their disability. Such medical care could, in many cases, have improved both their disabling condition(s) and their overall situation in life.

The Medicare waiting period is an often insurmountable barrier for individuals with disabilities. It offers frustration and emotional distress to people and families who are already hurting. Individuals with disabilities perceive the waiting period as being “punitive” and inherently unfair. Some individuals feel that the government is “just waiting for” people to die. Moreover, for many individuals, it will cost more in the long run for health care and services as individuals’ conditions deteriorate because they are not receiving appropriate treatment. *NADE strongly believes that Social Security disability beneficiaries and their families, who are forced to deal with the trauma of disability, should not then be forced to deal with deteriorating health, financial pressures and emotional frustration caused by the Medicare waiting period.* Medicare coverage at the onset of an individual’s disability would relieve not only a significant financial, but also a significant emotional burden for disability beneficiaries and their families.

Most Americans with disabilities wish to lead active, healthy and productive lives and believe that employment is an important key to achieving this goal. Improvements in health care and early intervention of needed medical services could increase rehabilitation successes, provide greater employment opportunities and enhance the ability of people with disabilities to be more active and productive. **Early interventions and access to needed health care services would provide not only greater emotional and economic stability for disabled individuals, it would decrease costs to the Social Security disability program as well.**

The Social Security Administration has proposed some new demonstration projects under their Work Opportunity Initiative to help overcome the barrier that the 24 month Medicare waiting period poses for those disability beneficiaries and applicants who wish to work. The demonstration projects provide supports, incentives and work opportunities to people with disabilities at the early stages of the disability determination process. Three of these proposed demonstration projects provide immediate medical benefits to applicants for disability benefits by offering comprehensive, affordable health care coverage. This allows beneficiaries to receive needed medical services early on in the onset of disability to enhance their vocational profile to return to work. Such interventions are not only good business practice from a financial standpoint, but from a humane and public relations aspect as well. **NADE fully supports all initiatives and demonstration projects designed to assist disabled individuals in their efforts to obtain needed health care, promote self-sufficiency and return to work.**

NADE members strongly believe that claimants and their families, who are forced to deal with the onset of disability, should not then be forced to deal with the lack of health care coverage. For both Social Security and SSI disability, the definition of disability is the same, the medical listings are the same, and the adjudicative procedures used to process the claims are the same. However, the health care benefits provided to those who are found disabled are not.

Disabled individuals who receive SSI disability benefits are eligible to receive health care coverage under the Medicaid program immediately upon being found eligible for SSI benefits. Because the SSI disability beneficiaries can receive health care benefits

*Continued on next page*



***Waiting Period Position Paper continued***

*immediately, the perception clearly exists that the individual who has worked and contributed to the nation's workforce and economy is penalized for having done so! Most Social Security disability beneficiaries face a daunting combination of low income, poor health status, heavy prescription drug use and high medical bills. They spend their days trying to survive and get their most basic human and health care needs met. Access to the health care services provided by Medicare is crucial if individuals with disabilities are to maximize their potential, avoid far more costly hospitalizations and long-term institutionalization and lead fuller and more productive lives.*

Congress passed the Americans with Disabilities Act in 1990 with the specific goals of ensuring equal opportunity, full participation in society, independent living and economic self-sufficiency for individuals with disabilities. Eliminating, or at least reducing, the 24 month Medicare waiting period would not only be an extremely humane gesture for these disabled workers and their families, it is perfectly aligned with the American with Disabilities Act and it is the *"right thing to do!"*

NADE recognizes that there are costs involved with eliminating the 24 month Medicare waiting period. Thus, our members would also support an incremental approach to reducing this. Some of the costs could be offset by a reduction in federal Medicaid expenditures. The Government Accountability Office (GAO) stated in their report on transforming government to meet the 21<sup>st</sup> century challenges that "policymakers must confront a host of emerging forces and trends shaping the United States ... and ... accompanying these changes are new expectations about the quality of life for Americans and ... testing the continued relevance and relative priority for our changing society" of existing federal programs is critical to ensure "fiscal responsibility and facilitating national renewal." NADE agrees with GAO and feels it is time to change the Medicare waiting period to bring it into the 21<sup>st</sup> century.

*Approved by NADE Board August 2005*



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### *NADE for You, continued from page 36*

In summary, Ms. Marshall stated: "NADE represents you. But equally important, I think, NADE represents the Social Security and Supplemental Security Income disability programs. The diversity of our membership gives us a unique level of credibility. No other organization has as diverse a membership who share the same goal—a disability program that is equitable and fair, that is administered in such a way that those who should receive benefits do and those who should not, do not".



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**STATEMENT FOR THE RECORD  
Of the  
NATIONAL ASSOCIATION OF DISABILITY EXAMINERS**

**Shari Bratt, President**

**Prepared For The  
HOUSE COMMITTEE ON WAYS AND MEANS  
Subcommittee on Social Security  
Subcommittee on Human Resources**

**Hearing  
On  
Commissioner of Social Security's  
Proposed Improvements to the  
Disability Determination Process**

**September 27, 2005**

Chairman McCrery, Chairman Herger, and members of the Subcommittees, on behalf of the National Association of Disability Examiners (NADE), I am presenting a written statement for the record on the Commissioner's proposed improvements to the Social Security Disability Determination process.

NADE is a professional association whose purpose is to promote the art and science of disability evaluation. The majority of our members are employed by state Disability Determination Service (DDS) agencies and thus are on the "front-line" of the disability evaluation process. However, our membership also includes SSA personnel, attorneys, physicians, and claimant advocates. It is the diversity of our membership, combined with our extensive program knowledge and "hands on" experience, which enables NADE to offer a perspective on disability issues which is both unique and pragmatic.

NADE members, whether in the state DDSs, in SSA or in the private sector, are deeply concerned about the integrity and efficiency of both the Social Security and the Supplemental Security Income (SSI) disability programs. Any change in the disability process must promote viability and stability in the program and maintain the integrity of the disability trust fund by providing good customer service while protecting the trust funds against abuse. Quality claimant service and lowered administrative costs that the American taxpayer can afford should dictate the structure of any new disability claims process. In addition, in order to rebuild public confidence in the disability program, the basic design of any new process should insure that the decisions made by all components and all decision makers accurately reflect a determination that a claimant is truly disabled as defined by the Social Security Act.

NADE believes that for people with disabilities, it is crucial that SSA reduce any unnecessary delays and make the process more efficient. However, any changes in the process must be practical and affordable and be implemented in a manner that allows appropriate safeguards to assure that timely claimant service is improved. NADE is not convinced that all parts of the Commissioner's proposal will achieve this and is concerned that some of the proposed changes will, in fact, increase both administrative and programmatic costs.

For the past decade, SSA has attempted to redesign the disability claims process in an effort to create a new process that will result in more timely and accurate decisions. Results of numerous tests undertaken by SSA to improve the disability process have not produced the results anticipated. The experience of past pilots has shown that ideas that may sound good in theory have proven to be inadequate to meet the demands for service and affordability when implemented on a wide scale.

There is a pervasive public perception that "everyone" is denied disability benefits at the initial and reconsideration levels, and is then allowed only when they reach the Administrative Law Judge (ALJ) level. This perception is totally inaccurate as SSA statistics show that 80 out of every 100 disability beneficiaries were allowed by the DDS. Numerous references are made to making the "right decision as

early in the process as possible.” NADE certainly supports that goal but wishes to point out that sometimes the right decision is a denial. The processing delays that appear to be of greatest concern to the Commissioner and to the public are delays that occur not at the DDS, but in association with the appeals process.

In her initial comments about a new disability approach, the Commissioner indicated the foundation for the approach was the successful implementation of an electronic folder system (eDIB). The proposed disability process improvements are built upon this new electronic folder system which is expected to reduce processing time by 25%. For eDIB to be successful, it is critically important that adequate infrastructure support and proper equipment to make the process work effectively and efficiently is in place. Until eDIB is fully implemented nationwide, it is impossible to determine critical service delivery issues that impact on daily case processing. NADE supports continued rollout of an electronic disability folder for the obvious reasons of administrative cost savings in terms of postage and folder storage, as well as time savings from mailing and retrieving paper folders. At the same time, it must be recognized that an electronic disability case process may have a negative impact on case production capacities at the DDS level.

While eDIB may be rolled out nationally in all state DDSs and territories except New York, it is not in use by all adjudicators in all components, and it remains to be seen how the system will handle the increased volume of work and number of users when it is implemented completely in all components of disability case processing. Overall, we believe that the impact of eDIB on the adjudication process will be positive. However, it is critical, that in this period of finite resources, those resources (including personnel) not be diverted from eDIB to develop the structure and procedures necessary for implementation of a new adjudicative process.

While the hardware and software for eDIB is in place in the vast majority of DDSs, the system is currently only utilized by a small minority of disability examiners. Its capacity and success remain to be seen as more users are involved. Until eDIB is fully operational, (including the predictive software to identify Quick Disability Determinations), we do not believe it is appropriate to make widespread changes in the adjudicative process. The full implementation of eDIB in itself may result in a significant reduction in processing time at all levels of adjudication without additional changes to the adjudicative process.

In addition, tools which have been demonstrated to improve efficiency, such as dual monitors, are not yet available to all adjudicators and medical consultants. Because eDIB is still a work in progress, refinements, upgrades, and improvements are frequently necessary. The impact on the system as a whole when these refinements are accomplished is unpredictable, but at the present time frequently results in slowing or shutting down the system, or parts thereof. Since DDSs process over 2 ½ million cases on an annual basis, any shut-down of the system equates to significant loss of work processing capacity. *Even a shut-down of only five minutes a day equates to over 1,250 work hours lost on a daily basis due to system instability.* Currently, many DDSs experience far more than 5 minutes per day of system instability problems.

In addition, some upgrades and improvements to the system require that the adjudicator relearn basic functionality which again impacts on the ability of the DDSs to process the huge number of cases they receive in a year. Upgrades to the system are essential to insure that the system operates as efficiently as possible, but it must be recognized that there is a resource impact every time a change is made.

While NADE recognizes the need for, and supports, SSA’s commitment to move to an electronic disability claims process, this tool will not replace the highly skilled and trained disability adjudicator who evaluates the claim and determines an individual’s eligibility for disability benefits in accordance with SSA’s rules and regulations.

Although we understand that electronic case processing procedures are being developed, there is currently no process in place to handle continuing disability reviews (CDRs). The inability to process the CDR workload electronically could impact both administrative and program costs, as well as compromise program integrity.

NADE recognizes and supports the need to improve the disability decision making process. We are concerned, however, that the Disability Process Improvement Initiative, with its increased reliance on medical specialists and attorneys, and its elimination of the triage approach currently being used in 20 DDSs, could increase both administrative costs and program costs. If the first level of appeal following a denial by the DDS is handled by a Reviewing Official who is an attorney, rather than by a trained disability adjudicator, such as a disability hearing officer, and if medical specialists replace programmatically trained DDS medical consultants, the disability program’s administrative costs will almost certainly increase. We also suspect program costs will increase as more claims are allowed on appeal by individuals who lack the requisite medical and vocational training and background to view such claims from the perspective of SSA’s definition of disability. Adjudicators evaluating Social Security and SSI disability claims must appropriately and interchangeably, during the course of adjudication, apply the “logic” of a doctor, a lawyer and a rehabilitation counselor following SSA’s complex regulations and policies to arrive at a disability decision. Training in all three of these areas is critical to effectively and efficiently adjudicate these cases accurately and in a timely manner. Failure to do so carries enormous consequences for the Social Security Administration and the huge number of citizens who call upon the Agency for assistance.

***NADE's Response to Proposed Improvements continued***

In the proposal for a “quick disability determination” (QDD), appropriate claims would be identified and referred to special units in the DDS for expedited action. NADE supports the QDD being made by the DDS. However, we feel that this workload would not necessarily require that the most experienced disability adjudicators should be assigned to process these QDD cases. In our considerable practical experience with such cases, we have found that the complexity of these cases is minimal and we believe that the expertise of the more experienced disability adjudicators is best allocated to process the more complex cases. We believe that each DDS Administrator should be allowed the ability to assign their more experienced personnel to process claims as they believe best suits the needs of the DDS and the people they strive to serve.

If the decision is made to require the most experienced disability adjudicators to process QDD cases, then NADE believes that it is not necessary to require MC “sign-off” on these fairly straight-forward allowance cases. In addition, specialized units for processing QDD cases are not necessary as they would reduce production in other types of caseloads normally handled by experienced adjudicators.

It is imperative that predictive software for identifying QDD cases be manageable and accurate. It has been proposed that adjudication of 98% of these QDD cases will result in a favorable determination of disability. If that goal, as well as the goal of a 20 day processing time is not met, action will be taken to remove this caseload from the DDS. NADE does not support these punitive actions.

It is important to note that in Title II claims those persons found disabled under the Social Security Disability program must complete a five month waiting period to receive benefits. *A disability allowance decision, no matter how quickly it is processed, will not solve the problem of having to wait five full calendar months before being able to receive any cash benefits.*

The Commissioner’s proposal has recommended establishing a federal Reviewing Official (RO) as an interim step between the DDS decision and the Office of Hearings and Appeals (OHA). An interim step outlining the facts of the case and requiring resolution of the issues involved could help improve the quality and consistency of decisions between DDS and OHA components. NADE supports an interim step because of the structure it imposes, the potential for improving consistency of decisions, reducing processing time on appeals, and correcting obvious decisional errors at the initial level. However, the Disability Process Initiative is unclear as to the method the RO would use to gather necessary medical evidence. If additional evidence is needed at that point, it would likely result in increased costs at the DDS level to provide for consultative examinations.

There is little, if any, data to support a conclusion that the interim step between the DDS decision and OHA must be handled by an attorney. In fact, a 2003 report commissioned by the Social Security Advisory Board to study this very issue recommended that this position NOT be filled by an attorney. Assessment of eligibility under the Social Security Disability program requires that the adjudicator at every level possess a great deal of program, medical and legal knowledge. As currently proposed, the only qualification indicated for a Reviewing Official is that he/she be an attorney. Individuals who are hired into this new position without previous experience in the disability program will require extensive training and mentoring for a period of at least one year. It is also unclear in the proposal who would be responsible for the training and supervision of the RO.

NADE believes that a review at the interim step should be conducted by a medically and programmatically trained individual such as a disability hearing officer (DHO). The DHO has received additional training in conducting evidentiary hearings, decision writing and making findings of fact, along with detailed case analysis and program information. The DHO currently makes complex decisions using the Medical Improvement Review Standard (MIRS). There is currently a training program in place for Hearing Officers in the state DDSs. This program could easily be adapted to training experienced disability professionals to perform RO duties. Since a DHO infrastructure is already in place, national implementation of the DHO alternative could occur very quickly. Using an already established structure will prevent creation of a costly and less claimant friendly federal bureaucracy. There would be extreme cost considerations if attorneys were to fill these positions as currently is suggested.

NADE strongly supports the Commissioner’s emphasis on quality as described in the proposal. There is a need for in-line and end-of-line quality review at all levels of adjudication. Accountability and feedback at each level is crucial. Nationally uniform decisions with consistent application of policy at all adjudicative levels require a consistent and inclusive quality assurance (QA) review process. A well-defined and implemented QA process provides an effective deterrent to mismanagement, fraud and abuse in the Social Security Disability program. We believe an improved quality assurance process will promote national consistency, and in turn, will build credibility into the process. NADE also supports quality reviews at all levels of adjudication, including DDSs, Reviewing Officials, and ALJs.

In regard to the Federal Expert Unit (FEU), NADE believes the FEU can provide DDSs with additional access to medical and vocational expertise. Qualification standards for inclusion in the FEU should not exclude the knowledgeable state agency medical consultant. DDS medical consultants are trained in program requirements, and the majority of the cases they review include multiple impairments. Having specialists review each impairment individually is a time consuming, costly proposal. Specialty consultants with limited scope and experience cannot fully assess the combined effects of multiple impairments on an applicant's functioning. DDS medical consultants are not only medical specialists—physicians, psychologists or speech/language pathologists—they are also SSA program specialists.

Although members of the FEU will surely be highly qualified to treat patients in their respective fields of specialty, they will also require extensive training in the area of determining disability. Evaluating eligibility for Social Security disability is a far different area of expertise than treating patients. There is a very real difference between clinical and regulatory medicine, and it takes at least a year to become proficient in Social Security disability rules and regulations. Again, the responsibility for training, mentoring, and supervising these experts is not established in the Commissioner's proposal.

Salaries for both the RO and members of the FEU will be much higher than those of Disability Examiners and Hearing Officers at the state DDS. In addition, there will be a lengthy period of time while the individuals assigned to these new positions will not be capable of independent assessment of disability eligibility. While we support the concept of the FEU being used to supplement the expertise of the Medical Consultant at the DDS, we feel that most cases at the initial level should continue to be reviewed and evaluated by state agency medical consultants.

NADE supports the proposal to retain a *de novo* hearing before the ALJ, with the requirement that the ALJs provide in their decisions an explanation as to why they agree or disagree with the rationale of the RO's decision. NADE also supports the concept of timely submission of evidence as outlined in the proposal. Submission of evidence no later than 20 days appears reasonable and may increase the ability to process hearing requests in a timelier manner.

NADE also supports the establishment of a Decision Review Board consisting of both ALJs and Administrative Appeals Judges serving staggering terms to conduct disability review functions. NADE agrees that a gradual roll-out process would be most effective. The NPRM proposes to gradually eliminate the Appeals Council only in those regions where the changes in the NPRM have been implemented and NADE supports this concept.

In summary, NADE's key recommendations are to implement only strategies which balance the dual obligations of stewardship and service. These are:

- Do not divert resources from eDIB until the system is fully operational in all DDS locations.
- Eliminate or reduce the five-month waiting period for Social Security beneficiaries.
- Extend Presumptive disability provisions to Social Security disability claimants.
- Fully integrate the Single Decision Maker into any new disability process.
- Utilize the current infrastructure of DDS Disability Hearing Officers as an interim appeals step.
- Require adequate training in the medical and vocational program requirements for all decision makers in all components.
- Include both in-line and end-of-line reviews at all levels of the process.
- Recognize that technology is only a tool. It does not replace the highly skilled trained disability examiner.

NADE appreciates this opportunity to present our views on the Commissioner's Disability Improvement plan and we look forward to working with the Social Security Administration and the Congress as the Commissioner continues to refine the disability process.



## Social Security Advisory Board Concerned About Solvency; Hopeful eDIB Will Expedite Decisions

By Claudette Benser and Theresa Furget, Michigan DDS

NADE was pleased to have the Chairman of the Social Security Advisory Board Hal Daub as one of the keynote speakers at the recent National Training conference in Boise, Idaho. He opened his remarks by expressing his sadness for the grievous losses sustained recently by SSA and DDS employees due to the hurricane disaster across the Gulf Coast. He noted that SSA responded quickly and effectively to assure the vital flow of SSA payments to those who have been displaced by this catastrophe.

At full strength the Advisory Board has seven members. Three are nominated on a bipartisan basis by the President. The other four members are appointed by the Republican and Democratic leadership of the House and Senate. Mr. Daub has been chairman of the advisory board since January 2002 and his term will end in September 2006. A frequent speaker at NADE conferences, Mr. Daub explained that the advisory board is an independent group charged with studying and making recommendations concerning the SSA program. They meet on a monthly basis, usually in Washington DC. Each year they hold public hearings around the country to get a better understanding of how the program operates and to get the views of people like NADE members who are actually carrying out the day to day work of the agency. The Board then publishes their findings and makes recommendations to Congress concerning the SSA program.

Earlier this year, the Board published a report, *Retirement Security: the Unfolding of a Predictable Surprise* that takes a look at Social Security in the larger context of health care programs, private pensions, employment, and all of those elements that need to work together so that Americans can look forward to a secure retirement. In 1997, the Board issued a report that set out the dimensions of the problem and the many

reasons why it is important to address the solvency problem sooner rather than later. Mr. Daub noted that the report also points out that there are many proposals out there from which policymakers can choose in order to craft a solution. Their advice was not acted on and the Board had to update and reissue that report again in 2001. The Board has now updated it once more and it was to be issued that week of the conference. He added that there have been 25 congressional proposals under consideration in recent years and with a bipartisan compromise there may real progress on this looming problem.

Currently the Advisory Board is looking at the processing time of claims going through the appeals process. While the Board is concerned about this, they're hopeful that eDIB will eventually speed the process up and cut down on overall processing time. The Board has been following the Commissioner's New Approach and plans to host a series of panels concerning the proposed changes. One of the panels will involve NADE. Mr. Daub emphasized that during the NPRM (Notice of Proposed Rule Making) process, it is critical that comments be made as the comments can have a significant impact on the final rulings. The Advisory Board recognizes that changes are needed to the process to eliminate bottlenecks. Mr. Daub urged NADE members to communicate their thoughts to the NADE leadership.

The Social Security Advisory Board is still working on, and continues to pursue, changing the definition of disability (*Mr. Daub introduced this at the Kansas City NADE training conference in 2004*). He noted that NADE has recently issued reports pointing out contradictions in the Disability and Medicare waiting period provisions. A report from the Advisory Board can be expected by next year which will begin to point the way to resolving this definitional problem. He also emphasized that SSA should be helping claimants to be-



Chairman Daub addresses attendees at the NADE conference.

come independent, self-sufficient and getting back into the work force. As the disability program now stands, an individual must be proved to be ineligible to work, and there's no incentive to get back into the work force. These contradictions are really intertwined with the basic question of defining disability. He acknowledged that finding an answer will not be easy. He stated, "For the benefit of both the individuals and society, we should not be telling people with impairments to concentrate on proving what they cannot do. We should be helping them to overcome those impairments so that they can play a productive role in our economy and enjoy the benefits of independence and self-support." The Ticket to Work program is a start in the right direction.

Mr. Daub concluded by reaffirming, what he has stated in the past, how impressed he and the Board are with the NADE organization. He praised the commitment of the membership to increasing skills and training by attending the regional and national training conferences. Also he recognized the organization's commitment to excellence through the certification program for examiners and excellent periodical. He stated that he is always impressed by the President and other leaders of our organization, by their excellent testimony in Congress, the thought-provoking position papers, and by their willingness to come visit with the Board and our staff to help the Advisory Board understand NADE's perspective on disability issues.



## Stem Cells Discussion Update

by Jonathan Jaffee MD, NADE in NH Medical Consultant

Stem cells have the unique potential to develop into many different cell types in the body. In theory they could serve as a sort of repair system for the body as they can divide without limit to replace other cells damaged or diseased cells. When it divides, a stem cell may remain stem cell or it may become more specialized cells such as a muscle cell or red blood cell.

Stem cells have been used, successfully in bone marrow transplants for over 40 years in the treatment of leukemia and lymphoma and several other blood disorders. They have also been used, experimentally in the treatment of many other diseases in recent years. They appear to have potential in the treatment of cancer, of birth defects, and more recent research has shown exciting possibilities in the field of what has come to be called regenerative medicine—the use of these cells-or products derived from them- to stimulate the body to heal itself, reverse diseased, and replace

damaged, organs. This has greatest promise in the treatment of cancer, diabetes, spinal cord injury and other neurological diseases, and cardiac disease such as congestive heart failure.

There has been promising research in devastating neurological diseases such as ALS, Alzheimer's disease Parkinson's disease and spinal cord injury, and most recently—it has been shown that implantation of adult stem cells-obtained from bone marrow- into a heart that has developed heart failure can significantly improve cardiac function.

Stem cells may be obtained from adult cells, umbilical cord blood samples, or from human embryos. Stem cells used clinically are almost exclusively from bone marrow cells. Stem cells used in scientific research however are standardized and have been obtained from human embryos that are a few days old that have been cultured to create cell

lines that can be grown indefinitely in the lab distributed to other researchers.

The use of embryonic stem cells for such research, however, became controversial as the use of human embryos, and techniques used to reproduce the stem cells were offensive to some. In August 2001, President Bush issued guidelines for stem cell research, placing significant limits on stem cell research in the US.

Stem cell research has just begun, and new discoveries are announced frequently. In April 2004, animal studies showing promise in treatment of heart failure were released, and the first human study showing that injection of adult stem cells, (harvested from a patient's own marrow), injected into damaged heart tissue, could improve heart failure as shown by the EF.-a measure of pump efficiency.

For more on stem cells, and their potential  
<http://www.stemcellresearchfoundation.org/index.htm>  
<http://stemcells.nih.gov/index.asp>  
<http://www.time.com/time/2001/stemcells/>



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Exception: All new memberships received between January through June will receive an expiration date of June 30th of the following year. NADE does not prorate dues.

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## What Has NADE Done for You Lately?



NADE President Martha Marshall began her presentation with a discussion of what NADE is, what NADE is not and what NADE has done for the membership lately.

NADE is a professional association whose mission is to advance the art and science of disability evaluation. It was established in 1963 by a group of DDS Administrators as a Division of the National Rehabilitation Association (NRA) to address concerns unique to the Social Security disability program. (At that time most DDS offices were part of the state's Vocational Rehabilitation Agency). In 1978 NADE separated from NRA in order to more effectively address DDS issues.



*Martha Marshall hands off the President's gavel to Shari Bratt, NE.*

NADE's mission, as defined in NADE's Constitution, is to foster, promote and participate in activities designed to:

- Increase the understanding of disability programs by the medical community and the general public. Develop high standards of professional and ethical service to the general public.
- Improve the documentation of applications for disability benefits and the evaluation of medical and vocational information obtained in connection with such applications.
- Provide a forum for the discussion of problems related to adjudication of disability claims.
- Develop professional standards and training opportunities for all individuals engaged in adjudication of disability claims.

These core values form the basis from which NADE operates and are kept as the focus in everything NADE does and how NADE serves its members.

Although they share many of the same concerns, NADE is not a union. Nor is it strictly an examiner association. While membership consists primarily of individuals working in the State DDSs these include in addition to Examiners: Administrators, Supervisors, Professional Relations Officers, Quality Assurance Analysts, Hearings Officers and Medical Consultants. NADE's membership also includes Central Office and Regional Office personnel, attorneys, consulting physicians and psychologists, and advocates. NADE serves its members, and the Social Security and SSI disability programs, by advocating for:

- Resources (including sufficient staffing and funding to process cases; and the necessary tools, such as dual monitors, to do this work efficiently)
- Dedicated funding for CDRs (processing this workload in a timely manner is important to maintaining program integrity)
- Expansion of the Cooperative Disability Investigation (Fraud) Units
- Elimination or reduction of the 5 Month Waiting Period
- Elimination or reduction of the 24 Month Medicare Waiting Period
- Changes to the Commissioner's Disability Process Improvement Plan (DPI) in order to retain the Quick Disability Determination in the DDS; retain Medical Consultant availability in the DDS; delete the requirement that the Reviewing Official must be an attorney; and to not divert resources from eDib, which is still a "work in progress" to implement the new process.

*Continued on page 27*

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