the
NADE
ADVOCATE

A Publication of the National Association of Disability Examiners Volume 21, Number 3 Summer 2005

Regional Conference Issue

Quad Conference Coverage

Emma's Gifts: A Story of Love, Hope and Possibility

A film screening

by Mary Sue Bryan, Georgia DDS

This inspirational film, presented at the recent NADE Quad-Regional Training Conference in Raleigh, is a valuable resource to pediatricians, hospitals, teachers and parents, as well as disability examiners and others who deal with, or evaluate, individuals with Down syndrome.

The presenter for this screening was Mitzi Corrigan, Emma's mother. She believes that Emma can touch people's lives in special ways. This documentary "serves to enable Emma and other children with special needs to have an even greater impact on the world."

Emma and her twin sister Abby were conceived by in vitro fertilization. During the pregnancy, the girls parents, Mitzi and Mike Corrigan, had high hopes, dreams and expectations for their children. But when they were born, Mike knew from the beginning that something was not quite right. He was initially tipped off when the doctor and nurse were whispering. Then his worries were reinforced when Emma was admitted to intensive care and hooked up to IV lines and monitors. Mitzi felt as though she had lost control of the situation from the moment she saw the expressions on the faces of the health care providers. At home she worried that she wasn't doing enough to help her child because she didn't know **how** to help her. Mike, whose job involved working with deaf children thought, "if she was only deaf, I would know what to do". Although they loved both children, it would take time and a great deal of effort to learn to deal with the issues that surrounded

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Southwest/Pacific Bi-Regional Conference

Quality Assurance From The Regional View

by Bill Dunn, Texas DDS

Tom Berling is a Disability Program Administrator for the Dallas Region of SSA. He is also a member of TADE who has been a member of NADE since 1974. In fact, he told us he was the editor of the NADE Advocate many years ago. He spoke about Quality Assurance at the SWADE/PADE Regional Conference in Oklahoma City on April 13, 2005.

Berling began by noting that, when we talk about quality assurance, we are usually talking about accuracy, not quality. He noted that efforts are being made within SSA to adopt a broad definition of quality that includes dimensions of accuracy, timeliness, productivity, cost and service. He noted that an in-line review approach is actually a better way to promote the broad definition of quality. However, he noted that the current means for SSA to measure quality assurance are both end-of-line reviews; Pre-Effectuation Reviews (PERs) and Federal Quality Assurance reviews (FQAs).

Many more cases are reviewed under PER than in the FQA samples; but the FQAs are what are used to evaluate the state DDSs. PERs are done on half of all Title II and concurrent cases. These are not picked on a random basis. They are selected from targeted areas that are expected to be error-prone.

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IN THIS ISSUE:

President's Message

As I began thinking about what I wanted to say, in this my last President's column, I realized that this is the perfect opportunity to consider what NADE has accomplished this year– and what issues we are likely to face next year.

The National Training Conference in Kansas City, with its mix (typical of NADE training conferences) of relevant SSA program information and medical lectures, provided a wonderful beginning for my term. And then there was the Hearing.

Before we left the conference, Past President Terri Klubertanz, President-elect Shari Bratt, Legislative Director Mimi Wirtanen and I were preparing testimony to be presented on September 30, 2004 before the Subcommittee on Social Security and the Subcommittee on Human Resources joint hearing on the Commissioner's new approach to "improve the disability decision making process". It's always a challenge trying to condense our written testimony into the five minutes allowed for oral presentations and Mimi and I spent a lot of time on the plane and in the room editing and rehearsing.

In October NADE was invited to attend the Association of Administrative Law Judges (AALJs) annual conference in Orlando, Florida. Not only was this an interesting experience (and they couldn't have been nicer to me!), it's important to be reminded occasionally that we really are all in this together and that the ALJs' and DDS's struggle with many of the same problems.

Mississippi's DDS Director Sheila Everett graciously included both NADE and MADE (Mississippi Association of Disability Examiners) in the Mississippi DDS's "IDA and eDib Birthday Celebration" as they became the first DDS to transition to a fully electronic (folderless) process. It was an honor to be part of this celebration and a tribute to the professionalism of our members.

In April OKADE members in Oklahoma hosted a Bi-Regional training conference for the Southwest and Pacific Regions; THADE members in North Carolina hosted the Quad-Regional training conference for the Southeast, Great Plains, Northeast and Mid-Atlantic Regions; and in May IADE members in Illinois hosted the Great Lakes Regional Conference. These were all excellent! NADE members always seem to manage to produce conferences which include outstanding, informative and relevant training AND social activities which offer an opportunity to relax and make and renew friendships. The National Training Conference in Boise promises to offer the same excellent training opportunities and interesting and fun social activities. I hope to see you there.

But NADE does more than promote training and networking. We continue to monitor all proposed changes in the law and in the regulations to weigh how they impact on the Social Security and

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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.

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You may e-mail articles in text format to
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Please also forward a hard copy.

Supplemental Security Income disability programs and/or on the disability professionals who have to implement them. We also continue to advocate for those changes which we believe will improve the disability program and the decision making process.

Shari, Terri, Mimi and I had a series of meetings prior to the mid-year Board meeting in March. We met with the Commissioner, several key congressional staff members and staff from other government offices, including the Congressional Budget Office and the Office of Management and Budget. At each of these meetings we discussed the need for adequate resources and the rationale for requesting additional Cooperative Disability Investigation (CDI) fraud units. We shared NADE's proposal for a new "Approach" to disability evaluation: the need to retain both the "Quick Decision" and Medical Consultant availability in the DDS; to retain the Single Decision Maker concept; to use DDS Hearing Officers, rather than attorneys, in the appeal step between the DDS decision and the ALJ hearing; and the need for in-line and end of line quality review for all components. Several guest speakers attended the Board meeting itself. (Detailed information about those presentations was included in the Spring *Advocate*.)

The Social Security Administration has accelerated their plans to revise the Medical Listings. Current plans are to "turn over" all of the Listings in the next two years, and to provide an opportunity for interested people, including professional associations, advocacy organizations and users to send comments and suggestions for updating and revising the Listings before a "Notice of Proposed Rulemaking" (NPRM) is written. To do this they are issuing "Advance Notice of Proposed Rulemaking" (ANPRM). In this issue you will find NADE's response to the ANPRMs on Hearing and Vestibular Disorders; Language and Speech Disorders; Neurological Disorders and Respiratory Disorders. I want to thank everyone who provided input on these. I especially want to acknowledge the Ad Hoc DDS Medical Consultants Committee for their input. This group has been incredibly helpful, not only with these ANPRMs, but with NADE's earlier responses to the NPRMs on genitourinary impairments, cardiovascular impairments and chronic liver disease and our Position Paper on *"Improving the Disability Decision Process*" prepared for the Institute of Medicine's Open Forum.

You can't survive as NADE President without a lot of help from a lot of people. I feel a little like an Academy Award winner because I know that as soon as I start "naming names" I'll leave out someone important. So I'm going to limit myself to two, because this is a first year for these two committees. The first is the Ad Hoc DDS Medical Consultant Committee chaired by C. Richard Dann, MD. The second is the Professional Development and Certification Committee. No, this is not the first year for that Committee but it is the first year that re-certification has been an issue. Because NADE strengthened its certification requirements three years ago, everyone who was certified on or before April 2002 needed to apply for re-certification this year in order to remain certified. Thanks to Barbara Styles and her Committee, this is being accomplished with amazingly few problems.

Looking back I have to say this has been an interesting and productive year for NADE. But challenges remain. A lot of challenges! There are eDib and DMA issues that need to be resolved, and this process will continue to require "tweaking" and refinement. Implementing the Commissioner's new approach to disability evaluation will create its own set of challenges. We will probably never have all the resources (including training) that we need for developing and adjudicating claims. We still need to truly implement the "One SSA" concept and develop new and better communication between and among the different components– Central Office, Regional Office, the Field Offices, DDSs and ALJs. Maintaining morale despite all these challenges may be the biggest challenge of all. NADE has a role to play in meeting all of these challenges. We can continue to advocate for resources. We can address problems and suggest solutions from a realistic, practical, "hands on" perspective. Our state, regional and national conferences will continue to offer not only high level training opportunities but the kind of support and networking, and just plain fun that resolves problems and improves morale. So stay involved, at what ever level of involvement is most comfortable for you, because as I've said before now, more than ever, we need NADE and now, more than ever, NADE needs you.

Martha Marshall

NADE CALENDAR OF EVENTS:

Kentucky Association	**Salato Center at the Game Farm**	**Frankfort KY**	**July 27, 2005**
Contact: Christy Burton	**(phone: 1-800-928-8050 ext 4177)**		
Michigan Association	**Holiday Inn South**	**Lansing MI**	**August 5, 2005**
Contact: Mimi Wirtanen	**(mimi.wirtanen@ssa.gov)**		
Ohio Association	**Villa Milano**	**Columbus OH**	**August 12, 2005**
Contact: Susan Smith	**(susan .x.smith@ssa.gov)**		
2005 National Conference	**DoubleTree Riverside**	**Boise ID**	**Sept. 10-15, 2005**

Emma, ontinued from page 1

Emma's condition.

The film conveyed how Emma was fun and funny and silly and how sister Abby learned from Emma as well as vice versa. They received emotional support and education from other parents in their communitywith similar problems. Mitzi is now aerving as co-chair of the Roots & Shoots committee with the Down Syndrome Association of Charlotte. She is also part of the Parent Support Network of the ARC and is president of the school Parent Teacher Association.

Early intervention is important for children with Down syndrome. These children have special problems and they need to begin developing as early as possible since they tend to have low muscle tone, slower motor skills, and they talk much later than their non-Down cohorts. Most children with Down syndrome need individual speech and physical therapy.

The film was an inspiring look into the lives of all involved. It encouraged us to challenge negativity in social institutions and to break down the old stereotypes that still exist that these children do not hold promise or contribution to our lives and society.

In the end, the message comes across that this family has discovered that Emma's differences are precious gifts that will take them on a journey that few families ever experience. Emma's interaction with her sister and other people that she touches is a miracle that bears sharing.

The film is a great resource for parents of children with special needs and educators who seek information about early intervention and building an inclusive classroom setting. It was a heartwarming and motivational film that was worth every one of its 45 minutes. At the end of the film, Mrs. Corrigan said, "I want her to go to college, get married, have children. Is that asking too much? I don't know."

Anyone wishing to purchase a copy of the DVD or VHS tape, or wanting more information, please visit the website at www.emmasgiftsfilm.com or contact Mitzi Corrigan at 704-995-4215.

The Onset, Course, and Outcome of Schizophrenia And Other Major Mental Illnesses

Presented by: Dr. Brian Sheitman,
Clinical Director,
Dorothea Dix Psychiatric Hospital

by Barbara Styles, Alabama DDS

Dr. Brian Sheitman presented an interesting broad analysis of schizophrenia and other mental illnesses at the recent Quad-Regional Training conference in Raleigh NC. He began his presentation by giving an overview of the way mental illnesses are described in the Diagnostic and Statistical Manual – IV; the reference guide for diagnosing and understanding mental disorders.

The DSM-IV breaks down the diagnosis of mental disorders into five axis: clinical disorders; personality disorders; general medical conditions; psychosocial and environmental problems; and, a global assessment of functioning (GAF).

Axis 1 diagnoses include childhood onset disorders; delirium/dementia; substance abuse disorders; schizophrenia and other psychotic disorders; mood disorders; and anxiety disorders. Axis 2 information is categorized as Cluster A: paranoid, schizoid, or schizotypal; Cluster B: antisocial, borderline, histrionic or narcissistic; and Cluster C: avoidant, dependent, or obsessive-compulsive. Axis 3 diagnoses may include any general medical condition, such as diabetes, obesity, hypertension or significant pain complaints.

Axis 4 and 5 includes data which is more functional in nature. Information cited on Axis 4 may relate to problems with family/friends, education, work, housing, finances, access to healthcare, legal problems, etc. Axis 5 is a rating given by the clinician on a scale of 0-100 which indicates the severity of the patient's symptoms. Any rating below 51 indicates serious symptoms which may significantly interfere with the patient's day to day functioning.

Dr. Sheitman then went on to discuss schizophrenia in more detail. He indicated that persons with this disorder may carry many different diagnoses such as schizoaffective disorder, bipolar disorder, schizophreniform disorder, or major depression with psychotic features. Generally, those who manifest symptoms usually begin showing the first signs in late adolescence or early adulthood. Males usually have an earlier onset than females. Typically, there is an episode known as a prodrome, which can be 3-5 years prior to the onset of psychosis. Many patients are psychotic 1-2 years before they seek any treatment. There is a high probability of a genetic basis for schizophrenia; the concordance rate for identical twins is 30-50 percent. If the two parents are schizophrenic, their child is 40 percent more likely to show the same tendencies. It is unlikely that the specific genetic cause will be discovered in the near future. Neuroimaging of the brain has been somewhat helpful for research, but has limited clinical utility.

Schizophrenia impacts many domains. If a patient is psychotic, they evidence thinking problems or disorganized thoughts. There are often problems with violent behavior; 50 percent of these patients attempt suicide and 10 percent will succeed in that attempt. Schizophrenia impacts mood and often causes depression. Patients also may show problems with cognition, their working memory – the ability to "juggle things in their head."

Dr. Sheitman's discussion then turned to treatment options and the various uses of antipsychotic medications. Many are available to be used; however, he stated few are totally effective in controlling all the symptoms. Unfortunately, many of the medications produce undesirable side effects, such as weight gain, movement disorders or dystonic reactions. The evidence shows that most patients need antipsychotic medications over long periods of time; without them, 90 percent tend to relapse. Compliance with medication seems to be the biggest factor in relapse prevention. Even on medication, 30 percent still relapse, but subsequent episodes may be less intense. Social support, decreased stress, and abstinence from substance abuse are all very important in relapse prevention. Despite popular theories, the evidence does not support that these patients will deteriorate with each episode into a "downward spiral." While few patients return to their pre-morbid baseline, indications are that early treatment is possibly more effective. The most effective time to begin treatment, may be during the prodrome period.

Finally, it was noted that the situation with this group is not hopeless. Many newer medications are being used in conjunction with antidepressants, mood stabilizers and even anti-Parkinson's drugs to decrease problems such as social withdrawal and social cognition problems. In the "Vermont State" study, patients were tracked over 30 years. Most of the patients were out in the community (not completely recovered) but functioning at some level.

There is another treatment being tested in Connecticut called the Program for Assertive Community Treatment (PACT). In this program, treatment providers go to the patients, instead of requiring them to come to a designated location for medications. This program seems to be cheaper in the long run, since patients have shown fewer hospitalizations. This most useful recovery model helps the patient focus on their strengths instead of their deficits.

* * *

Case Development And Evaluation of Communication Disorders

Presentation by
Kim Bigelow, M.A., CCC-SLP
and
Linda Trent Braddock, M.Ed., CCC-SLP

by Ron Atchison, Florida DDS

How many of you have heard the old sayings "you are talking but not saying anything" and "you are listening but not hearing?" The presentation given by Speech and Language Pathologists Kim Bigelow and Linda Trent Braddock at the NADE Quad-Regional Training Conference in Raleigh NC provided the answers to both. You would also have gained new insight for developing your Speech and Language claims.

In a tag team approach Ms. Braddock began by talking about the focus of the presentation which was Speech and Language Case Development. How do you know you have a speech and language case? The first step is to review the file for the allegations, either directly stated or implied. Of course you start by looking at the sources of evidence, test findings, and functional information from third parties. In all of this investigation, you must remember that you are working on the file of a real person who needs your help.

Ms. Bigelow talked about the role of the Speech-Language Pathologist (SLP) and their responsibilities to evaluate and treat communication impairments from birth to adult. She pointed out that, while she and Ms. Braddock work for the DDS, Speech-Language Pathologists work in a wide variety of settings. Ms. Bigelow stated that communication is a wide term but her focus was on verbal communication. Speech is sound production and its components are articulation and phonology which refers to the little sounds that go into making words. She defined language as the combination of form and content behaviors encoded into meaning. Additionally she defined Pragmatics as the social use, function, or goal of language; in other words, what you are trying to convey to your audience. The rate or rhythm of speech is characterized as your fluency or smooth flow of speech and your voice refers to your pitch, vocal quality, intensity, intonation and prosody.

Ms. Braddock re-entered the discussion by stating that the basis for case evaluation is the medical evidence of record (MER) in the file. The speech-language pathologist has to follow the trail of evidence looking to see if the client has or is receiving speech therapy and by whom. If so the source has to be contacted for a complete report on the client's condition. As always, you must have proper authorization for release of information prior to requesting such information.

Ms. Bigelow addressed specifics relating to adult speech-language problems. She discussed some of the physical causes of adult interruption in normal speech and hearing such as stroke, head trauma, laryngectomy, stuttering, and developmental disabilities. To properly develop an adult case, you need activities of daily living (ADLs) and information from other sources such as

Continued on next page

Quad Conference continued from page 5

witnesses or third party sources. These sources could be a caregiver, family member, friend, or associate who is aware of the problem.

Childhood speech-language issues were discussed by Ms. Braddock who pointed out the need to know if there is an allegation of such problems and if so is the child receiving therapy services. She indicated the need to secure copies of current speech and language testing if available as well as functional communication information which is covered in the teacher questionnaire and the Speech and Language Professional Report form. School information along with professional testing is vital in the development and adjudication of children's claims.

So what happens when you review all available information and you cannot make a determination? According to Ms. Bigelow, it's now time to review the file for a possible speech-language consultative exam (CE). It's best to have the Speech-Language Pathologists review the claim prior to ordering the CE so that you are assured of both the necessity of the exam and the information needed. Ms. Bigelow stated that both she and Ms. Braddock are excellent resources and are there to assist the adjudicator whenever possible. She also spoke to the success of the Speech and Language Professional Report form which has worked well for the North Carolina DDS.

Last, but not least, both Ms. Bigelow and Ms. Braddock spoke of "Avoiding the Summertime Blues." That of course is when school is out and moving the DC claims is almost impossible without school information. During this special training session they emphasized the need to expedite DC claims before schools close for the summer.

Ms. Bigelow and Ms. Braddock gave an excellent presentation and the North Carolina Disability Determination Services is lucky to have two dedicated professionals on staff.

Spot Lighting A Few Dim Corners - By The Numbers

Presented by: Gary Greer,Ph.D.

by Patrice Proehl-Burnett, MSW,
Missouri DDS

Dr. Greer provided several aspects of mental illnesses and disease processes by correlating them with the medical listings. Beginning with Executive Dysfunction Syndrome and a roar of laughter from the crowd, after a few minutes Dr. Greer inquired about his new comedy routine. It was quite unplanned actually; my guess is we all thought he had a new definition of a disability examiner/counselor. But in actuality it was quite the opposite. Executive Dysfunction is commonly termed dementia and involves a person's ability to execute his environment:

- **Conation** (motivation, goal setting)
- **Planning** (executing the action/goal)
- **Initiating** (starting the goal)
- **Persevering** (staying to the plan, overting obstacles)

There are key behaviors that a client will possess that cue the examiner/counselor that this disorder is in process:

- **Lack of Curiosity**
- **Never asks questions about a situation**
- **Demonstrates no concept of cause and effect**

There are also coordinating physical processes that can induce this syndrome. They include the obvious: closed head injury, stroke, HIV and the not so obvious: cardiac arrest, multiple sclerosis, and meningitis.

Research has indicated that dysfunction in this area is difficult to assess in the clinical setting alone. Due in fact Demonstrating, mental retardation should never be judged by score alone. It is important to remember that intelligence and organicity testing contain a standard error of measurement which can fog the overall picture (ability to function).

Comparatively, the negative symptoms of Schizophrenia illustrate that there is something abnormal occurring. These abnormalities are encompassed with in five aspects of function:

- **Affect** (flattened, mask appearance)
- **Alogia** (not speaking much"poverty of speech"
- **Avolition** (apathy)
- **Anhedonia** (can not derive pleasure, socially withdrawn)
- **Inattentiveness** (cannot sustain concentration, persistence, or pace)

The key behaviors that are exhibited include:

- **Withdrawal from external reality**
- **Attempts to institute external structure produce more withdrawal**

Correlating, Pain syndromes were delineated as involving sensation and affect. Sensation is derived from nerve fibers:

- **Slight sensations are emitted by slow fibers.**
- **Large sensations are emitted by fast fibers.**

Affect is comprised of interpretations. In chronic pain syndromes the client is on alert, on guard; he/she will worry about the pain and anticipate it. These behaviors are also evident in generalized persistent anxiety and depression. Dr. Greer emphasized that pain receptors have physical locations but pain behaviors are learned, primarily through conditioning.

Mental retardation should never be judged by score alone. It is important to remember that intelligence and organicity testing contain a standard error of measurement which can fog the overall picture (ability to function).

Therefore, with all the processes or syndromes indicated above it is imperative to assess the client's adaptive functioning and delineate the correlations that guided your conclusions. Adaptive functioning was defined as involvement of the following components:

- **Adaptive skills** (communication, self-care, home living, social skills, use of community resources, self direction, functional academic skills, work, leisure, health and well-being)
- **Independent function** (cleanliness, appearance, care of clothing, ability to travel)
- **Physical development** (sensory and motor)
- **Economic activity** (money handling and budget, shopping skills)\
- **Language** (expression, verbal comprehension, social language development)
- **Numbers and Time, Vocational, and self-direction.**

Finally, the client's and third party descriptions of daily activities are going to provide the examiner/counselor insight to the client's adaptive functioning. The medical/psychological impairment correlated with the adaptive functioning associated with the specified impairment will elicit allowances with Listings 12.02 A4; 12.03 1, 3; 12.05A, B, C, D; 12.06A 1a.b.c; 12.04A1a-h; 12.07A 2f.

Preparing DDS Medical Consultants for eDib

Presented by Dr. George Albright,
Maryland DDS Chief Medical Consultant

by Carol A. Harper, DCADE,
Kentucky DDS

Dr George Albright, Chief Medical Consultant for the Maryland DDS spoke to conference attendees, many of whom were consultants in the various DDS offices in the four regions. He stated that he knows change is difficult to accept at times but we are moving forward and it is an exciting time for SSA and DDS.

Dr. Albright stated that there are many benefits to the paperless process that may not be fully appreciated. He talked of being able to read the MCS signatures and knowing where the claim is at all times. The days of lost files will be a thing of the past. The system will assist the medical evaluator through the sequential process. He stated that the MCS in Maryland had some difficulty with navigating through the files and reading the medical evidence on the screen. It will be difficult to get everyone to change with the new process but it is important that everyone work together and be receptive to the new work process. He hopes the logic of their decision making will be more evident since the folder entries will be in chronological order and thus will be clearer to the reviewer of the file. There could be a loss of program knowledge due to retirements. The Maryland DDS has had two retirements since last summer.

Dr. Albright concluded with some final thoughts and observations on the future ideas to improve the current work process. He stated that the system has to be able to keep up with the volume of people working on the system. He cited the problem of the system slowing down as the internet gets busier later in the day on the East coast and the West coast is just beginning. He stated that we will need to continue to review the ergonomic demands on the employees with the increased time in front of the computer. He also talked about the need for dual monitors in order to manage the review of medical records and electronic file. He predicts that it will be important to have dual monitors for the employees to be able to efficiently handle the electronic process successfully.

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Great Lakes Conference continued from page 32

Because of excessive cloudiness in fall and winter, the Great Lakes region is subject to producing SAD. However, SAD cases are found in the sub-tropics, so it is a nation-wide phenomenon.

LIGHTS ON

First line treatment is bright, full spectrum, light therapy, even for 20 or 30 minutes per day. “Dawn light” is a bulb that comes on gradually, mimicking the dawn. Pharmacotherapy may also help.

Light is a metaphor for healing, hope and spirituality. Light gives us information about where we are in the day-night cycle, DeSanctis said. We depend on external energy and this source is at a deficit for SAD sufferers.

* * *

Neuro-Psychological Testing In Cases Of Traumatic Brain Injury (TBI)

Presentation by Ronald Zec, PhD,
Board Certified Clinical
Neuropsychologist

INDICES OF SEVERITY OF HEAD INJURY

A common categorization of head injuries into mild/moderate/severe tells one little about the nature of the effects on function. It usually refers to length of time in a coma — more than 10 days in a coma means there will be permanent brain damage.

Recovery in a mild case begins in 3 to 10 days – the rate of that recovery is related to the amount of the recovery. Dr. Zec stated, “The way to obtain information to fully assess function after TBI is to obtain a complete, full day neuropsych testing report.”

OBJECTIVE, RELIABLE TESTING:

Suggested psychological tests include: IQ: attention/concentration tests (several); new learning and memory testing; and academic performance.

The (Wide Range Achievement Test (WRAT) is less useful as a screening tool to assess brain damage. This and other tests are used to assess pre-trauma level of ability. If pre-trauma testing is not available some *assumptions* can be made from the individual's past achievements based on Mean I.Q.s:

High School grad = 105
Bachelor Degree = 115
Advanced degree = 125

There is a question, which has never really been addressed, whether a person with a drop in IQ is worse off than someone who's IQ has always been low.

EXECUTIVE FUNCTION / FRONTAL LOBE

This area of the brain manages an individual’s ability to:

- Set goals
- Carry out goals
- Recognize mistakes
- Correct mistakes
- Foresee consequences

COGNITIVE DEFICITS AFTER CABG (Coronary Artery Bypass Grafting)

While this subject has been studied, results are so far contradictory. Patients on a heart-lung machine during surgery had worse cognitive states afterward. However, these patients had worse heart disease and were more cognitively impaired prior to surgery.

OBTAINING ADL INFORMATION

To get the needed data about TBI claimants, a check-off list of questions will not be complete enough. Dr. Zec begins by asking open-ended questions and follows up with more directed ones. He uses the following asking format: *“Compared to (pre-morbid) before, considering that as 100%, compare yourself to that now.”*

He independently interviews family members, focusing on the claimant over-estimating his/her abilities and lacking insight into problems. He follows that part of the interview with some of the “100%” questions in particular*: “Are you able to finish things? How would you describe your reading comprehension? Are you able to juggle multiple chores? Do you have to study harder for grades?”*

* * *

Obesity Surgery Not just a cosmetic problem

Presentation by John P. Sutyak, M.D., EdM.,
Southern Illinois University,
Professor of Surgery

Watch for some new terms: “morbid obesity” is now replaced by the more descriptive “clinical significant obesity.” The “Lap Band” is a surgery more common outside the U.S., but now approved by the FDA and practiced here. **It is easily reversible, adjustable, and the patient can eat normally after surgery.**

Lap band surgery consists of a plastic, inflatable band wrapped around the stomach with access to a "port" just under the abdominal skin. Air can be inserted or removed to change the size of the stomach, if there is need for this.

The highest class of obesity is the more-than-50 BMI. Obesity is driven by the way we live. However, chromosomes for obesity have been identified.

There is a long list of co-morbidities such as severe arthritis, sleep apnea, depression with a genetic link and malignancies (due to alterations in hormones). Those co-morbid conditions are being more successfully treated, meaning that a disabling condition is less likely to exist than in the past.

SURGERY has been found to have a lower risk than the risk of obesity-related deaths. Often insulin can be discontinued; most surgeries other than lap band require life-long follow up with iron and other supplements to avoid vitamin deficiencies. Most likely, we'll be seeing more "Lap Bands" and less disability.

Infants And HIV

Presentation by Subhash Chaudhary, M.D., Professor of Pediatrics and Infectious Disease, Southern Illinois School of Medicine

Focus on HIV infected mothers

Worldwide, there has been an 81% decrease in child AIDS cases but a substantial increase in orphaned children. ***One percent of all AIDS cases are pediatric.***

Several new practices and tests are responsible for the decrease. Of the babies who contract the disease, one-fourth to one-third contract HIV infection during pregnancy, and two-thirds to three-fourths during delivery. Birth by Caesarean section decreases the chance of transmission. If the pregnant mother is given AZT intravenously, the incidence of perinatal infection is greatly decreased. *Zidovine* is also given or added.

HIV cells become part of the baby's DNA, which becomes part of the cells. Unfortunately,there is no medicine to reverse it.

THE PCR TEST is preferred for children. It tests DNA and is confirmed by a second test. Using this, 95 percent of cases can be detected by one month of age. Rapid progression with symptoms within a few months means death by age 4. A case with symptoms at about 8 years is considered a slow progression of the disease.

THINK HIV involvement if there are multiple manifestations of: lymph adenopathy, hepatomegaly, failure to thrive, oral candidiasis not responding to treatment, cardiomyopathy, opportunistic infection, parotitis, fungus and others.

Medical professionals predict poor prognosis for those with onset in the first year, or severe wasting, or neurological disorders, or pneumocystic pneumonia. Treatment is given to all infants including pneumocystis prophylaxis.

NADE wishes to recognize our general level corporate sponsors:

Bertha Litwin & Associates, Sherman Oaks CA

Chris Catt Consulting, Louisville KY

Hillside Medical Evaluation Group, Inglewood CA

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S & L Medical Group, Van Nuys CA

Venetian Diagnostic Group, Los Angeles CA

Be It Resolved…

by Karen Keller, Resolutions Chair

If you have an idea or recommendation for improvements to the disability program, submit a resolution to the NADE Resolutions Committee. Remember, NADE speaks FOR you. This is your opportunity to speak up and be heard. The Social Security Disability program is in the midst of many changes, and these changes affect all of us. Often the best ideas come from those who work directly with the program. Any chapter or single member can submit a resolution to the committee. Our committee reviews all proposed resolutions and presents them to the NADE board. The delegates at the NADE conference have the final vote.

If you would like to submit a resolution, use the format listed below, and submit it to any of the committee members:

WHEREAS:
(statement of the facts)

WHEREAS:
(more relevant facts)

WHEREAS:
(continue as needed)

THEREFORE, BE IT RESOLVED:
(the opinion/position you want
supported by NADE)

If you have any questions, please feel free to contact me. I look forward to hearing from many of you.

Resolution Committee Members:

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Concord NH 03301
603-271-3341, ext 339
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Employment Opportunity

Social Security Reform Leader and NADE Friend Passes Away at Age 91

by Jeff Price, Past NADE President

Former U.S. Representative James Jarrell (J.J.) Pickle, also known as "Jake," who served in Congress from December 1963 to January 1995, passed away June 18 at his home in Austin, Texas. Rep. Pickle served as Chairman of the Subcommittee on Social Security in the House of Representatives during the turbulent 1980s when Social Security's retirement and disability programs came under fire. Recognized as a zealous protector of Social Security, Congressman Pickle led the effort to strengthen Social Security from its real and perceived problems.

One of his bills, passed in 1983, raised the eligibility age for full retirement benefits from 65 to 67 while another installed the Medical Improvement Review Standard (MIRS) for Social Security's disability program. Although NADE has recently voiced some criticism of MIRS, this legislation was supported at the time because it was proposed in response to the heightened number of continuing disability reviews that erroneously terminated the disability benefits for tens of thousands of people. Although many eventually won their appeals, the massive backlog of appeals took years to resolve. Between 1983 and 1987, almost every state Governor had issued a moratorium, preventing their State DDS from conducting any CDRs, unless and until Congress acted to protect the rights of disabled Americans. Rep. Pickle convinced Congress to adopt a nationwide moratorium on the CDR process while his Subcommittee studied the issue and then, in addition to MIRS, he steered legislation through Congress that allowed for benefit payment continuation. In response, the moratoriums were lifted.

Congressman Pickle recognized the expertise of NADE's membership when the subject of the Social Security disability program arose. He solicited NADE's viewpoints on matters pertaining to disability adjudication and presented the Keynote Address at NADE's 1983 National Training Conference in Baltimore, MD. Throughout the congressional fight over Social Security in the 1980s, Congressman Pickle resisted efforts by both major political parties to demagogue the issue and declared, *"We can't inflame this subject. If we inflame it too much, nothing will get done, and if nothing gets done, the American people will have the right to throw us all out."* Pickle's advice remains true today and he will be missed.

NADE Candidates for Office

Charles "Chuck" Schimmels
Candidate for NADE President-Elect

I would like to take this opportunity to announce my candidacy for the office of NADE President-Elect for 2005 - 2006. I am asking the support of all NADE members in this endeavor. I offer my pledge that I will continue to work hard to maintain NADE's strong advocacy for our professional interests.

The office of NADE President is one that requires a great deal of time, dedication, and the support from their DDS Administrator, co-workers and most importantly their family. I have been offered that support and feel that now is the time for me to take this step for the Associations voice to continue to be heard.

I began my career with the Oklahoma Disability Determination Division in May of 1994. Shortly thereafter, in October of 1994, I became a member of NADE and OKADE (the Oklahoma Association of Disability Examiners). Throughout this time, I have served in various capacities, which include; SWADE Regional Director (2 terms), OKADE President (4 terms), OKADE Treasurer and SWADE President, twice. I have also volunteered for numerous committees, which have included; Awards, Elections and Fundraising, and membership on the Local, Regional and National levels. For the past two years, I have had the distinct privilege to serve as the NADE Treasurer. Since assuming these duties, I have performed the tasks associated with this position to the best of my abilities, in accordance with the By-laws established by NADE.

In 2002, I was honored to receive the Charles O. Blalock Award for the Southwest Region and also for NADE, nationally. This commendation is given in recognition of outstanding contributions to the advancement of NADE. I consider this a highlight of my professional career. I have also been honored to win the first ever SWADE Rookie of the Year award in 1996 and most recently the 2005 SWADE award.

My current classification is Disability Specialist IV with the Oklahoma DDD. My current assignment is to the DDD Training Module as a Case Consultant, where my responsibilities include mentoring and training recently hired Disability Examiner/Specialist staff.

As you are aware, NADE provides a platform for those involved on all levels of the Disability Determination process to express their opinion concerning all aspects of the program. NADE is a highly respected organization and is frequently asked to provide testimony to the U.S. Congress on matters concerning the SSA Disability process. I am proud to be associated with such an outstanding group.

With the continued advancement of technology and revisions to the Disability evaluation model, NADE will be faced with many ongoing challenges. It will be our responsibility and goal to assure that DDS's are provided with the resources needed to perform our duties to the American public at the highest level of quality and professionalism that is possible.

I believe my years of experience in serving NADE has prepared me to competently perform the duties of NADE President-Elect for 2005 - 2006 and to advance the cause of NADE. My dedication to the NADE organization and its mission is unwavering. I look forward to the opportunity to continue in my pursuit of quality service to NADE and its constituents.

Thank you for your consideration and support.

Juanita Boston
Candidate for NADE Secretary

I would like to announce my candidacy for the office of NADE Secretary for 2005-2006.

I have been a member of NADE since 1988. As an active member of THADE (Tar Heel Association of Disability Examiners) I served as President for three years, Vice President for one year, Secretary for three years and Board Member for six years. I have chaired many committees on the local level and served on many regional and national committees.

It has been an honor to serve as Secretary of NADE for the past two years. My knowledge of the disability program and the importance of NADE as a professional organization have been greatly enhanced. I am committed to NADE and willing to dedicate the time required to perform duties of Secretary.

Thank you for your support in the past and I respectfully request your support for 2005-2006.

Juanita G. Boston

Steven Segall
Candidate for NADE Treasurer

I would like to take this opportunity to announce my candidacy for NADE Treasurer.

I am a relatively new examiner having started with the Colorado DDS in December, 2003. I joined NADE shortly thereafter and attended both the national meeting in Kansas City last August and the Quad-Regional conference this past April in Raleigh. During this time I've had the pleasure to ask and have answered countless questions regarding not only the details of how one becomes a better examiner but participate in broad discussions of policy, practice and adaptation in the enormous program where we serve in such an integral capacity.

I've enjoyed attending and have personally benefited from the quality of NADE's training and education opportunities. More importantly, I have seen how NADE has become an effective advocate in providing timely and important input to Congress and the Commissioner which assist all of those involved in the disability process and, in particular, the claimants.

I've served as treasurer and as a member of the Board of Trustees for Temple Micah in Denver Colorado from 2000 to 2002 overseeing the congregation's growth from 50 families to 125 families, implementation of computerized bookkeeping and billing systems, prepared annual budgets and assisted in organizing their building acquisition plan.

In my first career I practiced family law for 23 years and have extensive litigation and advocacy experience. I enjoy fighting the good fight, particularly when limited to a mere 40 hour work week and affordable medical insurance is provided.

If elected to serve as NADE Treasurer, I would be honored to fulfill the fiduciary responsibilities and recommend to the Board any improvements which could better serve our organization. I respectfully request your support and thank you.

Non-Dues Revenue Committee Hosts…
Sale of NADE items,
Silent Auction,
& TALENT SHOW, too!

by Paula Sawyer
2005 Non-Dues Revenue Chair

It won't be long before many of us are reunited or brought together for the first time at the 2005 NADE National Training Conference in Boise, Idaho. This year, the Non-Dues Revenue Committee will be **very** busy hosting three separate events: the ongoing sale of NADE items adorned with the NADE logo, the annual Silent Auction and a first ever NADE members' Talent Show!

Annual membership dues and non-dues revenue provide the necessary resources enabling the NADE leadership to continue to effectively advocate on our behalf. During 2004-2005, the NADE Non-Dues Revenue Committee has been actively involved in identifying other worthwhile and entertaining activities that might not only raise more revenue for the national organization, but might also provide a venue where, as Marty Marshall has acknowledged, "the chapters and the individual members could be directly involved in a national event that promotes a sense of national unity and camaraderie." Thanks to the input of the 2005 Non-Dues Revenue Committee representatives, including Larry Heaslip and his chapter, NEADE which has hosted their own NADE talent show in Nebraska, the concept of a Non-Dues Revenue-sponsored NADE national talent show was born!

The Talent Show:

The Non-Dues Revenue Committee in conjunction with the NADE Board has formulated Guidelines for the NADE Talent Show which will take place at the NADE conference in Boise. Look for more details including time and place of the show in the National Training Conference Agenda to be distributed in Boise.

If you are planning on attending the NADE National Training conference in Boise, AND YOU HAVE A TALENT THAT YOU WOULD LIKE TO SHARE ON STAGE IN FRONT OF A LIVE AUDIENCE, please contact:Paula.Christofoletti@ssa.gov and sign up with Paula today!

The NADE Talent Show will take place during a two- hour slot on Monday night of the national training conference. Further details will be announced in the conference agenda to be distributed at registration.

Guidelines:

- **Each act will be limited to five minutes.**
- **Those in the audience will be asked to contribute $5.00 at the door.**
- **The show will take place at the hotel and the host chapter will provide performers with microphone, amps, and keyboards as available.**
- **There will be three (3) judges on hand to elect the finalist in each category of talent. (Musical, comedic, theatrical, gymnastic, instrumental, etc.)**
- **Audience members will then be invited to cast their votes for the Grand Prize Winning Contestant.**
- **The winning Grand Prize Winner will receive a gift donated by the Non-Dues Revenue Committee.**

The Silent Auction:

The annual NADE Silent Auction will again take place at the national conference in Boise. We are expecting each and every chapter represented at the conference to bring appealing, useful and easily transportable items to Boise. Each and every item will be offered up to the highest bidder. We encourage the chapters to **not only** donate baskets, but, to **also** showcase conversation pieces, state-produced crafts and other items not usually found in department stores or in your home state. Any chapter donating an item should deliver it to the registration table upon arrival. Be prepared to offer a minimum bid for that item and if donating a basket, please bring a typed list of what your basket contains. All highest bidders must be prepared to carry or ship their items home at their own expense.

NADE Sale Items:

All NADE "logo'd" items on the www.nade.org website will be available for purchase in Boise. Shipping charges have been added to all orders which are placed from your home chapter so this is the **perfect** opportunity to save on those charges by carrying NADE items home in your suitcase! If you have any requests for new NADE items that you would like to see available for sale, please e-mail me those requests by July 15, and we will do our best to introduce those items in Boise.

Focus on Gold Corporate member:

Since 1988, Medical Advocacy Services for Healthcare, Inc. — The MASH Program — has helped healthcare providers to maximize self-pay reimbursements by guiding self-pay patients in establishing their eligibility for medical public benefits. MASH provides advocacy services for hospitals of all sizes, government and health agencies, and physicians groups across the country.

Over the years, MASH advocates have . . .

- **Helped connect over a million patients to government benefits, and**
- **Recovered nearly two billion dollars in revenue for our customer providers.**

Seeing a need to aid people with disability claims who are not patients of customer hospitals, MASH established Disability Help, Inc. – DHI – about ten years ago. Working for individual clients rather than for hospitals, the work of DHI advocates is virtually the same as that of the MASH advocates, taking claims all the way from applications through Administrative Law Judge hearings.

The professionals of MASH and DHI have over 1400 years of hands-on agency and hospital experience. They share MASH's commitment to serving the disadvantaged. Their expertise covers such programs as . . .

- Medicaid/Medicare Programs
- Social Security Disability
- Supplemental Security Income
- Crime Victims Compensation
- County Indigent Healthcare

Contact information:
The MASH Program
Tim Lacy, Director, Human Resources
817/923-8900 x 426
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Editor's Note: **There was a typo in the Spring issue of the *Advocate* on page 4. We want to apologize for dropping the last three words on the article by Terri Klubertanz regarding Associate Commissioner Glenn Sklar's visit to the NADE Board. The sentence should have read: "Several national initiatives are either in place or underway with large providers of medical evidence and several national copy services."**

Statement For The Record
Of The
National Association of Disability Examiners
Martha A. Marshall, President

Prepared For The
House Committee on Ways and Means
Subcommittee on Social Security
Hearing On
on
Protecting and Strengthening Social Security

May 17, 2005

The National Association of Disability Examiners (NADE) wishes to thank Chairman McCrery, Mr. Levin and members of the Subcommittee for providing this opportunity to highlight the importance of Social Security's safety net to vulnerable populations, and the need to consider the impact of any Social Security reform initiatives on the Social Security Disability Insurance (DI) program and the citizens it serves. Although we believe that members of this Subcommittee are aware of the need to address the impact of any changes to Social Security on the DI program, this issue has received very little attention in the media or in the public discussions. We appreciate the Subcommittee addressing this issue.

NADE is a professional association whose mission is to advance the art and science of disability evaluation. Our membership includes Social Security Central Office and Regional Office personnel, attorneys, claimant advocates, physicians and others interested in the Social Security and Supplemental Security Income (SSI) disability programs. However, the majority of our members are employed in the state Disability Determination Service (DDS) offices and are directly involved in processing claims for Social Security and Supplemental Security Income disability benefits. The diversity of our membership, combined with our "hands on" experience, provides us with a unique understanding of the anticipated, and unanticipated, impact which changes to Social Security's funding or benefit structure will have on the Social Security disability program.

While it is possible for an individual and his or her family to prepare for retirement, it is rarely possible to prepare for disability. It is logical to assume that for the majority of disabled workers Social Security benefits constitute a larger percentage of their family's income than they do for retirees. It is essential, then, that any changes to the Social Security program, or initiatives to achieve solvency, do not adversely affect the disability benefits paid to these beneficiaries and their families.

Since 1956, when the Social Security Act was amended to provide benefits to disabled workers and disabled adult children, the disability program has become increasingly complex. Eligibility for disability benefits is an administrative decision that integrates medical, legal, vocational and functional elements. Individuals responsible for adjudicating these claims must possess a unique combination of knowledge and skills. The Government Accountability Office (GAO) acknowledged this in their January 2004 report, *Strategic Workforce Planning Needed to Address Human Capital Challenges Facing the Disability Determination Services*: "The critical task of making disability decisions is complex, requiring strong analytical skills and considerable expertise, and it will become even more demanding with the implementation of the Commissioner's new long-term improvement strategy and the projected growth in workload."

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 adjudicator who evaluates the claim and determines an individual's eligibility for disability benefits in accordance with Social Security's rules and regulations. The need for adequate resources of time and funds to provide for both the initial training of disability adjudicators and for their ongoing training is critical. The well trained and highly knowledgeable disability examiner is not only SSA's primary tool in delivering effective and efficient customer service, he/she is also the Agency's first line of defense against fraud and abuse. In fact, in previous testimony before this Subcommittee, SSA's Inspector General declared that, "…the well trained disability examiner is SSA's most effective tool in combating fraud and abuse, thereby strengthening the solvency of the trust funds." We will not take the time in this testimony to address the many recent examples of fraudulent claims that have received so much media exposure as we are sure that the Members of the Subcommittee have had their attention directed to these incidents. However, we do want to caution the Subcommittee that for every fraudulent claim that receives media exposure there are hundreds of such claims that do not. It is our strong belief that it will remain of critical importance for SSA's ability to maintain public confidence in the disability program that the individuals who process the claims have the technical expertise and knowledge to do so effectively and efficiently, and also have the requisite training and skills to enable them to remain alert and cognizant to the potential for fraud.

NADE recognizes and supports the need to improve the disability decision making process. We are concerned, however, that the Commissioner's new "Approach" to disability case processing, as described in her September 25, 2003 testimony before this Subcommittee, with its increased reliance on medical specialists and attorneys and its elimination of the triage approach currently being used in 20 DDSs, could potentially increase both the administrative costs and the program costs of the disability program. If, as has been envisioned, the first level of appeal following a denial by the DDS is handled by an attorney, rather than by a trained disability examiner, and if medical specialists replace programmatically trained DDS medical consultants, the disability program's administrative costs will almost certainly increase and, we suspect, so will program costs as more claims are allowed on appeal by individuals who lack the requisite training and background to view such claims from the perspective of SSA's definition of disability. We also suspect that less involvement in the decision making process by well trained disability examiners will lead to higher incidences of fraud and abuse.

The disability program is already under intense pressure and experiencing significant strain as trained disability examiners retire and Baby Boomers reach their most disability prone years. This unfortunate combination of declining institutional knowledge, frequent turnover in staff at both SSA and in the DDSs, and the potential increase in the number of disability claims will leave little room for ongoing training, especially since adjudicators will be required to spend the precious little time they have for training to learn the changes necessary to process claims under SSA's new electronic process. Again, we caution the Members of the Subcommittee that any legislation which would result in an increase in the number of initial claims filed, or an increase in the number of appeals to the Administrative Law Judge (ALJ) level will seriously jeopardize SSA's ability to process these claims. It is essential that the time and funds necessary for ongoing training for all adjudicators be provided as a commitment to ensuring effective and efficient customer service.

Currently when a disability beneficiary reaches retirement age his or her benefits are converted to retirement benefits. This move from disability benefits to retirement benefits is currently— and should remain–seamless. Disability benefits should not be lower than the individual's projected retirement benefits, nor should they be higher. In view of the fact that retirees, unlike disability beneficiaries, have had time to accrue additional retirement resources it could be argued that it is reasonable for disability benefits to be higher than retirement benefits. However, maintaining higher benefits for disabled workers than for retired workers who have contributed to Social Security for a full working life would create an incentive for workers to claim disability before retiring. This has the potential to create an administrative nightmare of increased claims, thereby reducing the time and resources available to process the normal caseload.

Many of those individuals filing for disability benefits rather than retirement benefits would, by virtue of their age, education and past work experience, be found eligible for disability benefits. These decisions, which are made at Steps 4 and 5 of the Social Security disability program's sequential evaluation process, are the most labor intensive claims to adjudicate. Determining whether or not a claimant is "disabled" at these steps in the sequential evaluation process requires the adjudicator to first assess the individual's current ability to perform work related activities and then determine whether, considering his or her age, education and past work experience, he or she can return either to past work (Step 4) or other work available in the national economy (Step 5)

The Social Security Advisory Board, in their October 2003 report, *The Social Security Definition of Disability*, described the difficulties inherent in making these medical/vocational decisions: "In the early years of the program, over 90 percent of cases were decided on the basis that the claimant's medical condition was specifically included in the listings or was of equal medical severity ...but the degree of subjectivity clearly is more substantial where the decision moves from entirely medical standards to an assessment of the individual's vocational capacity". Thus, the applications of those individuals filing for the higher disability benefits, rather than retirement benefits, are both more labor intensive and more subjective.

In previous testimony before this Subcommittee (July 24, 2003), we urged that adequate funding be provided for SSA's Continuing Disability Review, or CDR, process. We noted then that the CDR process, for every $1 expended, produced $9 in savings to the disability program. We continue to urge that adequate resources be allocated to keep the CDR process current. We further believe that it may be time for Congress to revisit the issue of the Medical Improvement Review Standard (MIRS), a congressionally mandated requirement, adopted twenty years ago in the wake of a significant increase in the number of disability reviews that resulted in recommendations for termination of benefits. MIRS requires that adjudicators first establish that there has been improvement in a claimant's medical condition before recommending that an individual's benefits be ceased. We will not argue this point at this time but we do wish to point out that claimants who are awarded disability benefits may have little financial incentive to seek medical improvement in their condition. In addition, claims that are allowed for impairments that, in hindsight, may not be viewed as truly disabling under SSA's definition of disability, cannot be reviewed and benefits terminated because it is nearly impossible to show medical improvement in such cases. NADE believes that this is an important issue, deserving of fresh dialogue, and we encourage this Subcommittee to examine this issue in the near future and to conduct hearings on this matter to ascertain if the MIRS remains relevant in the 21st century.

In our testimony before this Subcommittee and the Subcommittee on Human Resources on May 2, 2002, we highlighted many issues facing SSA's ability to provide effective public service while maintaining solvency. Those issues are still relevant today. We will not discuss them in length at this time; however, we believe they remain as critical today as they did three years ago:

- Solvency of Social Security trust funds
- The need to develop a more efficient disability claims process that is affordable
- SSA's inefficient and ineffective quality assurance process for its disability programs
- The need to eliminate the five (5) month waiting period for Social Security disability benefits
- The impact of technology on claimant service
- The need to prepare for the impending wave of retirements that face both SSA and the DDSs
- The need for bold leadership to provide direction for a program that has been managed, in large part, by short sighted responses to court decisions and other external pressures
- The need to truly implement the "One SSA" concept throughout the Agency
- The need for adequate resources to deal with the Agency's caseloads
- The need to meet other challenges, including the impact fraud has on the disability program, the need to resolve critical systems issues, and the challenge of ensuring that only the truly disabled are awarded benefit payments and that only those who remain disabled continue to receive these payments

In that same testimony, we highlighted other concerns we felt impacted on the Agency's ability to provide effective public service:

- The challenge to examine the current relevance of SSA's definition of disability.
- The challenge to revise the medical listings with attention as to how new and/or revised listings will impact on administrative and program costs.
- The challenge to find a replacement for the Dictionary of Occupational Titles.
- The challenge of dealing with increased instances of fraud.
- The challenge of providing effective service to non-English speaking claimants.
- The challenge surrounding the medical improvement review standard (MIRS) and its impact on program costs.

It is unfortunate that little progress has been made in many of these areas since we presented this testimony three years ago. The luxury of time is not something that can be taken for granted and we believe positive action is needed immediately to address these issues.

In conclusion, we again commend this Subcommittee for its positive action to hold this hearing to examine ways to protect and strengthen Social Security. We remind the Members of the Subcommittee, during your deliberations on this matter, to keep in mind the mission of Social Security, **"To promote the economic security of the nation's people through compassionate and vigilant leadership in shaping and managing America's social security programs."**

Thank you.

NADE welcomes our newest corporate members:

PSYCHOLOGICAL SPECIALISTS OF AUGUSTA
P O BOX 211008
MARTINEZ, GA 30907
and
SOUTH ATLANTIC MEDICAL GROUP
5504 E. WHITTIER BLVD
LOS ANGELES, CA 90022

NADE Correspondence

nade
National Association of Disability Examiners

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May 23, 2005

Mr. Mike O'Connor
Office of Disability Programs
Social Security Administration
6401 Security Boulevard
Baltimore, Maryland 21235-6401

Dear Mr. O'Connor:

The National Association of Disability Examiners (NADE) appreciates this opportunity to comment on the proposed Social Security Ruling, SSR 05-XX which clarifies how the Social Security Administration (SSA) considers opinions from sources that are not acceptable medical sources and how SSA will consider decisions made by governmental or nongovernmental programs on the issue of disability or blindness.

NADE supports this proposed new Ruling and believes that it will have a positive impact on the Social Security and Supplemental Security Income (SSI) disability programs.

Current Practice Regarding Consideration of Evidence

SSA published regulations on August 1, 1991 that set forth detailed rules for evaluating opinion evidence from "acceptable medical sources," including medical opinions and opinions on issues reserved to the Commissioner of Social Security. These regulations provide disability adjudicators with general guidance for evaluating all evidence in a case record, including opinion evidence, and define the principles to be used in weighing opinions from all types of acceptable medical sources, including treating sources, non-treating sources, and non-examining sources.

In preparing assessments of residual functional capacity, disability adjudicators are expected to address/refute opinions offered by acceptable medical sources but this is not required for opinions offered by other sources. This practice has the practical effect of giving greater legitimacy, whether deserved or not, to the medical evidence and opinion offered by acceptable medical sources over that offered by other sources. In some situations, this could have the effect of altering the decision on an applicant's eligibility for disability benefits.

What the New Proposed Ruling Will Do

The new proposed Social Security Ruling, although lacking the same force and effect as the statute or the regulations, will be binding on all components of the Social Security Administration and is to be relied upon as precedent in adjudicating cases. This new proposed Ruling declares that SSA will consider ALL evidence in the case record when making a determination regarding an applicant's eligibility for disability benefits. This includes opinion evidence submitted from acceptable medical sources, other medical sources, and non-medical sources. The weight such evidence may be entitled to will vary according to the particular facts of the case, the source of the opinion, the issue(s) that the opinion is about and other factors. The new Ruling further specifies that, *"The same factors used to weigh medical opinions from acceptable medical sources may also be used to weigh opinions from other sources because they represent basic principles that apply to all opinions, regardless of their source, such as how much the source knows about the individual, whether the sources has a specialty or area of expertise related to the individual's impairment(s), how much supporting relevant evidence the source presented, and whether* *the opinion is consistent with the record as a whole."*

Based on this new proposed Ruling, the determination of how much weight to give to a medical opinion from an acceptable medical source or an opinion from an "other" source is an individualized determination that will depend on the particular facts in each case. Each opinion, together with the rest of the relevant evidence in the case, should be evaluated to determine which findings are best supported by the evidence.

The new proposed Ruling declares that, all things being equal, medical opinions from acceptable medical sources will be accorded greater weight than opinions from other sources because acceptable medical sources are the most qualified medical sources. However, the new Ruling also declares that, *"…depending on the particular facts in a case, and after applying the factors for weighing opinion evidence, an opinion from an other source may outweigh the opinion of an acceptable medical source, including a treating source."* In order to avoid substitution of judgment on subsequent reviews, we would suggest that this statement be expanded to clarify that this example applies only when the treating source opinion cannot be given "controlling weight."

NADE Supports SSR 05 – XX

NADE believes the clarification contained in this new proposed Ruling regarding how much weight to assign to opinion evidence, including the ability for adjudicators to give greater weight to the opinions provided by "other" sources over "acceptable" medical sources when the circumstances justify doing so, will give disability adjudicators greater discretionary authority to make decisions that, in many cases, will be more informed and will more accurately reflect the facts in the case. In effect, the change provides "legitimacy" to the opinion evidence submitted from "other" sources and will allow disability adjudicators to give appropriate consideration to these opinions and address such opinions when preparing determinations of residual functional capacity.

It is important that all evidence and all opinions submitted in support of an individual's application for disability benefits be properly considered by the disability adjudicator, regardless of who provided the evidence and/or opinion, especially when opinions are supported by the objective medical evidence in the case. While we generally support the concept that greater weight should be given to opinions submitted by "acceptable" medical sources, and that controlling weight should be given to opinions submitted by treating sources when that opinion is supported by the evidence, we believe that medical evidence and opinions submitted by "other" sources have their place and should be given appropriate weight. Furthermore, when the particular circumstances in the case support such action, we believe that disability adjudicators should be able to assign greater weight to the medical evidence and opinions submitted by "other" sources over the evidence and opinions submitted by "acceptable" medical sources, especially in situations where the "other" source may have greater familiarity with the applicant and may possess greater knowledge of the effects that the impairment(s) has on the applicant's ability to function, especially in a work environment.

With regard to the decisions made by other governmental or non-governmental programs on the issue of disability, the new Ruling provides a definitive clarification that such decisions are not evidence but, rather, are opinions on the issue of disability and will be considered but not given any special significance. NADE supports this clarification, as we agree that decisions made by other governmental and nongovernmental programs are a reflection of opinion, especially since Social Security's definition of disability is almost universally different from that of other governmental and nongovernmental programs. Until there is a common definition of disability that is shared by one and all we do not believe that decisions made by one program can, or should, be binding on another. While this does lead to some confusion at times when disability applicants are awarded benefits from one program but denied benefits from another we believe that as long as there are different criteria for benefit eligibility this cannot be avoided. The decisions made by other programs can, and should, be properly considered as opinion evidence and assigned the degree of weight that the opinion deserves based on the factors previously cited.

Thank you for this opportunity to provide our comments.

Sincerely,

Martha Marshall

Martha Marshall, President
National Association of Disability Examiners

cc: Jo Anne Barnhart, Commissioner of Social Security
Lenore Carlson, Associate Commissioner, Office of Disability Determinatios
Glenn Sklar, Associate Commissioner, Office of Disability Programs
NADE Board of Directors

nade
National Association of Disability Examiners

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May 25, 2005

The Honorable Bill Thomas, Chairman
Committee on Ways and Means
United States House of Representatives
2208 Rayburn House Office Building
Washington, DC

Dear Mr. Thomas:

On behalf of the National Association of Disability Examiners (NADE), I want to thank you and the members of your committee for your work in investigating alternatives to strengthen Social Security. This is indeed a topic that has captured the attention of our organization and the American public.

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 and are responsible for the adjudication of claims for Social Security and Supplemental Security Income (SSI) disability benefits. Our members are very interested in what the future holds for the Social Security Disability Insurance (DI) program – both for its professionals and for its beneficiaries.

We have read with interest the testimony provided at the hearing before your committee on May 12, 2005. While there was some limited discussion regarding the Social Security disability program, we were concerned that this critical program did not receive broader consideration.

Social Security is absolutely vital to millions of Americans and the need to strengthen and preserve it for future generations has been widely discussed. However, while people with disabilities have a major stake in the Social Security reform debate, in much of the public discussion and analysis of the issue very little has been mentioned about how they, and their family members receiving auxiliary benefits, will be affected.

With the passage of the Americans with Disabilities Act, our government made a commitment to people with disabilities. That commitment must continue to be honored by giving very careful consideration to how changes in Social Security's funding or benefit structure will impact the disability program and the beneficiaries who depend on it.

We commend your ongoing efforts to provide a thorough analysis of the myriad of challenges that confront the Social Security program. One of these challenges is to strengthen Social Security, while protecting people with disabilities. Our organization looks forward to working with you in that quest.

Sincerely,

Martha Marshall

Martha A. Marshall
NADE President 2004-05

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June 13, 2005

Jim Julian, Director
Office of Medical Policy
Social Security Administration
Baltimore, MD 21235-0001

Dear Mr. Julian:

RE: Revised Medical Criteria for Evaluating Hearing Impairments and Disturbance of Labyrinthine-Vestibular Function, 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 the Listing of Impairments to better evaluate hearing impairments and disturbance of labyrinthine-vestibular function; and to offer our suggestions for improving the Social Security and Supplemental Security Income (SSI) disability programs for people with disabilities, including those people who have disabilities based on hearing loss or vestibular disorders, especially those who would like to work.

NADE is a professional association whose purpose 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 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. Our extensive program knowledge and “hands on” experience enables NADE to offer a perspective on disability evaluation that is both realistic and pragmatic.

NADE supports removing the reference to hearing aids in current Listing 2.08 *Hearing Impairments (hearing not restorable by a hearing aid).* Adults, as well as children, have varying abilities to use hearing aids effectively. However, although this is recognized in the preamble to the childhood listings (102.00 B), it is not mentioned in the preamble to the adult listing. In addition, obtaining this information is problematic at best and at times impossible. Claimants frequently have old, non-working or lost hearing aids. Relatively few testing facilities provide loaner aids and “stock” ear molds are not always effective. We believe that the listing should be based on unaided hearing at a decreased level (possibly lower than the current 90dB average) that would generally not be amenable to correction with a hearing aid. The preamble to this listing should delineate some of the tests audiologists use to assess validity of the audiogram, such as Stenger testing or Otoacoustic emissions testing.

We believe that specific language should be included in the preambles to Listings 2.00 and 102.00 to address cochlear implants. The parameters of hearing loss needed to meet, equal or functionally equal the Listings should be the same for those claimants as for those without cochlear implants.

The reference to “deaf mutism” in the preamble to the current listings (2.00B1) should be removed. This is an old term, offensive to many, which does not appropriately reflect a deaf person’s ability to speak.

NADE supports increasing the emphasis on gait and station for vestibular disorders with some definition in the preamble (2.00B2) of the term “frequent” when evaluating balance disturbance. Longitudinal information is essential to establish the impact of the vestibular disorder on the individual’s ability to function, and confirmatory testing is necessary to establish the presence of a Medically Determinable Impairment (MDI). This information should be available in the treating source records. If it is not, however, the preamble should describe which confirmatory tests can appropriately be purchased by SSA.

Hearing loss should not be a requirement to meet Listing 2.07 *(Disturbance of Labyrinthine-Vestibular Function)*. Meniere's disease is defined by hearing loss, tinnitus and vestibular problems. However, this represents only one kind of vestibular disturbance. Others are not defined by hearing loss. Thus, current Listing 2.07 represents only one kind of vestibular disturbance. We believe that the listing should reflect that the disability relates to the balance problems/vestibular disturbance, and not to the hearing loss..

SSA's current work incentives, which are available primarily to those individuals who have already been allowed benefits, have been only marginally successful. NADE is hopeful that one of the demonstration projects described in the Commissioner's new approach to disability evaluation will provide insights into improving the Social Security and SSI disability programs for people with hearing loss or vestibular disorders who would like to work. We support 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 have either lost their job or are unable to continue working due to their disability. Additionally, 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,

Marty Marshall
Martha A. Marshall
NADE President

cc: Michelle Hungerman
NADE Board

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June 13, 2005

Jim Julian, Director
Office of Medical Policy
Social Security Administration
Baltimore, MD 21235-0001

Dear Mr. Julian:

RE: Revised Medical Criteria for Evaluating Language and Speech 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 the Listing of Impairments to better evaluate language and speech disorders; and to offer our suggestions for improving the Social Security and Supplemental Security Income (SSI) disability programs for people with disabilities, including those people who have disabilities based on speech and language impairments, especially those who would like to work.

NADE is a professional association whose purpose 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

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. Our extensive program knowledge and "hands on" experience enables NADE to offer a perspective on disability evaluation that is both realistic and pragmatic.

NADE supports adding a new body system for language and speech disorders to the Listing of Impairments. Currently language and speech disorders are addressed in six separate listings in part A (applicable to individuals age 18 and over), and in 12 separate listings in part B (applicable to children under age 18). We believe that a separate listing, entitled "Communication Disorders", would provide a more focused, but also more comprehensive, means of evaluating language and speech problems. Labeling the new listing "Communication Disorders" would encompass both speech and language delays and deficits and be clear that an allowance that meets the listings is based on extreme limitation in the ability to communicative.

Although we will not reproduce the language of the Ruling here we would suggest that the information in SSR 98-1p, beginning with *"II. Terms and Definitions"* through *"Table 2. Factors Suggesting That the Duration Requirement Will Be Met"* be included in the Introduction to Part B of the new Communication Disorders listing.

The causative and contributing factors to communication disorders are typically heterogeneous and often multifaceted and interactive. For example, in a child or adult who has had a TBI, the communication disorder may be due to a combination of dysarthria, aphasia, decreased ability to comprehend and/or use abstraction, as well as pragmatic deficits due perseveration, circumlocution and disorganization, etc., combined with the impact of anxiety, depression and/or perhaps PTSD secondary to the injury and its effect on the individual's functioning.

The severity and expression of the communication disorder typically changes over time: in developmental disorders, with organic maturation and therapy; in those with acquired communication disorders secondary to neurological disease or injury, due to natural healing processes and rehabilitation. This factor of "improvement expected" could be adequately addressed if communication disorders were a separate listing with specific information (such as is provided in the SSR 98-1p Speech Table 2) that also addressed those conditions in which improvement is not likely or at what point no significant further improvement might be expected (e.g., from research on recovery curves with TBI's.)

The impact of a communication disorder must be assessed for adults as well as children with defined parameters for impairment severity (e.g. less than 50% intelligibility to strangers for adults and children 3 ½ and above). Severe to profound inability to comprehend language and/or communicate expressively due to speech and/or language deficits could cause marked deficits in ability to carry out ADL's and function socially. Moderately severe deficits would clearly limit the jobs in which one could function, particularly as more and more "simple" jobs are lost to mechanization, technological change and outsourcing. This is likely to become only more the case as we move further into a computerized world which requires increasing technological sophistication to utilize "ordinary" things in daily life and less and less work is available in which one can be an "apprentice" and more jobs require at least some technical schooling or ability to use a computer.

SSA's current work incentives, which are available to those individuals who have already been allowed benefits, have been only marginally successful. NADE is hopeful that one of the demonstration projects described in the Commissioner's new approach to disability evaluation will provide insights into improving the Social Security and Supplemental Security Income (SSI) disability programs for people with communication disorders who would like to work. We support 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 have either lost their job or are unable to continue working due to their disability. Additionally, 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,

Marty Marshall
Martha A. Marshall
NADE President

cc: Janet Bendann
Jane Deweib
NADE Board

NADE Correspondence

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June 13, 2005

Jim Julian, Director
Office of Medical Policy
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Baltimore, MD 21235-0001

Dear Mr. Julian:

RE: Revised Medical Criteria for Evaluating Neurological Impairments,
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 11.00 and 111.00 in the Listing of Impairments; and our suggestions for improving the Social Security and Supplemental Security Income (SSI) disability programs for people with neurological impairments 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.

The Epilepsy listings, if retained, should be adapted to include newer anticonvulsants that are not monitored with serum levels, as they were when the listings were last revised. "Good compliance" should be defined to include serum monitoring or evidence of good compliance documented by first and/or third party reports and confirmed by treating source records or contact with the prescribing physician.

Listing 11.04A *(Central nervous system vascular accident with sensory or motor aphasia resulting in ineffective speech or communication)* should be expanded to more clearly define "ineffective speech or communication"(e.g. less than 50% intelligible to strangers or processing errors greater than 50%)

Listings 11.07 A and 111.07 B1 (*Cerebral palsy with IQ of 70 or less)* should specify whether the "IQ of 70 or less" refers to the full scale IQ score or whether adjudicators should use the lower of the verbal, performance, or full scale IQ score. Additionally this listing should clarify whether the IQ score should be considered within the context of the capsule definition of mental retardation, or whether an IQ score by itself is sufficient.

Since many of the neurological listings refer back to Listing 11.04 criteria to evaluate severity, function based grouping of the Listings makes sense. NADE supports changing the current "disease-specific" format to a more inclusive "category format" such as "Demyelinating disorders" and "Movement disorders". However, examples of specific diseases that would be considered under the more inclusive categories (Multiple Sclerosis, Guillian Barre, transverse myelitis, encephalomyelitis, etc.) should be included in the function based categories. Because the pattern of impairment is less distinct in vascular disorders we do not support a category for "Vascular disorders."

We support retaining functional criteria in the neurological listings. However, the functional limitations required to meet a listing should be more specific and better defined than they are currently. The description of "*Persistent disorganization of motor function*" (currently 11:00 C) should be expanded to include clarifying and descriptive information similar to that found in the preamble to the Musculoskeletal System listings (specifically 1.00 B 2 a-d, "*How we define loss of function in these listings".)*

Listing 11.09C (*Multiple sclerosis with significant, reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, demonstrated on physical examination, resulting from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process)* should be deleted. Even good neurologic examiners can't demonstrate muscle weakness on repetitive testing within a single exam. Unlike myasthenia gravis,where it is possible to demonstrably fatigue the motor-endplate, the fatigue noted by MS patients is cumulative over a period of hours, rather than evident on a single exam.

Listing 11.11 (*Anterior poliomyelitis*) should also include "or Postpolio sequelae".

NADE recommends adding, "Coma lasting more than 30 days" to Listing 11:18 (*Cerebral trauma).*

In order to ensure that the late effects of traumatic brain injury (TBI) are fully documented and appropriately evaluated NADE supports deferring adjudication of the claim for up to six months post injury, if a finding of disability cannot be made earlier. <u>However, this additional time should not be included in the processing time statistics of either the DDS or the disability examiner handling the claim</u>.

SSA's current work incentives, which are available primarily to those individuals who have already been allowed benefits, have been only marginally successful. NADE is hopeful that one of the demonstration projects described in the Commissioner's new approach to disability evaluation will provide insights into improving the Social Security and SSI disability programs for people with neurological impairments who would like to work. We support 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 have either lost their job or are unable to continue working due to their disability. And 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,

Marty Marshall

Martha A. Marshall
NADE President

Cc: Regina Connell
Peggy Talley
NADE Board

Congratulations to the following NADE members on their recent retirements:

Sue Heflin (Mississippi)
Delores Navarrete (Mississippi)
Ione Klima (Minnesota)

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June 13, 2005

Jim Julian, Director
Office of Medical Policy
Social Security Administration
Baltimore, MD 21235-0001

Dear Mr. Julian:

RE: Revised Medical Criteria for Evaluating Respiratory System 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 3.00 and 103.00 of the Listings, and our suggestions for improving the Social Security and Supplemental Security Income (SSI) disability programs for people with respiratory disorders who would like to work.

NADE is a professional association whose mission is to promote 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 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. 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.

NADE acknowledges and supports the objectivity of properly performed pulmonary function testing. However the current SSA documentation standards for PFTs appear too stringent. We are concerned when a DDS allows a claim for an individual with significant clinical findings and obvious dyspnea at rest or on mild exertion and that claim is returned to the DDS by subsequent reviewers because the tracings are not "programmatically correct". This causes additional work for the DDS, delays the decision and creates unnecessary hardship for the claimant.

As the vast majority of pulmonary function testing is now done on flow sensing spirometers, and those devices have become more accurate, we would suggest that the revised Listings require a single calibration tracing, rather than three tracings at three different flow rates as is currently required. Otherwise PFT documentation standards appear appropriate. We support the need for original, or legible reproductions, of the spirometric tracings and do not support accepting calculation of FEV1 from a flow-loop tracing.

NADE strongly supports allowing pulse oximetry to be substituted for arterial blood gases (ABGs) in evaluating disabling pulmonary conditions for adults and children over the age of 12. In standard practice, pulse oximetry has all but replaced arterial blood gas sampling for oxygenation evaluation. Within structured guidelines (exercise under steady state conditions, preferably on a treadmill or bicycle ergometer) we believe SSA should accept exercise pulse oximetry in lieu of exercise ABGs.

We would support removal of Listing 3.02 C 2. ABGs are rarely, if ever, done during a period of "clinical stability". The current requirement of clinical stability and "two occasions three or more weeks apart and within a 6- month period" would not be found in the patient's medical record (MER) and the testing necessary to meet this Listing would not be ordered by the DDS due to the pain and potential morbidity of aterial blood sampling.

In pulmonary conditions the particular diagnosis is less important than the hypoxia and resultant loss of function. "Acute interventions counting" should be retained to assess the severity of asthma, cystic fibrosis, pneumoconiosis, bronchiectasis and mycobacterial infection. These could be grouped under a single listing requiring six acute interventions in a 12 month period with greater than 24 hour admissions counting as two. These acute interventions must be primarily for treatment of a pulmonary impairment. Additionally, the requirements of current Listing 3.04C could be included for all of the above conditions.

NADE Correspondence continued

We would support moving Listing 3.09, *(Cor pulmonale secondary to chronic pulmonary vascular hypertension)*, to the cardiac Listings, specifically to Listing 4.02.

We would suggest clearer parameters for Listing 3.10, *(Sleep-related breathing disorder*). Rather than treat this as basically a reference Listing we would suggest requiring two or more injuries from daytime somnolence within the past 12 months; or a sleep study showing "sleep efficiency" despite CPAP of 70% or less; or an O2 saturation averaging less than 90% despite CPAP; or an inability to utilize CPAP, and one of the above parameters.

SSA's current work incentives, which are available primarily to those individuals who have already been allowed benefits, have been only marginally successful. NADE is hopeful that one of the demonstration projects described in the Commissioner's new approach to disability evaluation will provide insights into improving the Social Security and SSI disability programs for people with respiratory disorders who would like to work. We support early treatment and intervention for disabling conditions with the provision of health insurance coverage and training either before, or in place of, providing cash benefits for those individuals who would like to continue working but have either lost their job or are unable to continue working due to their disability. Additionally, 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,

Marty Marshall

Martha A. Marshall
NADE President

Cc: Sharon Arden
Jane Deweib
NADE Board

Southwest/Pacific Bi-Regional Conference

Quality Assurance continued from page 1

For example, in one period, Affective Disorders and back cases under the age of 30 might be targeted; then the next six months, they might target Organic Brain Syndromes and heart cases. On the other hand, FQAs are taken on a random basis from allowances and denials. An equal number is taken from each DDS in the region. When SSA reports on accuracy rates, they are looking only at the FQA random samples.

He noted that 4300 PERs and 307 FQA reviews were done in the Dallas Region in February of 2005. There were 185 allowance returns and 23 denial returns. However, this is skewed by the fact that so many more allowances are reviewed due to the PERs. In fact, the Region has consistently had a higher accuracy rate for allowances than for denials when looking only at the randomly selected FQAs. The Region has consistently maintained an allowance accuracy rate of around 96-97% while denial accuracy rate has usually been around 92-93%, although it is only 91% right now. So it is our denials that we need to do a better job on, not our allowances.

Mr. Berling talked a little bit about individual body systems and the differences which exist between States in the Dallas Region and over time. For instance, he noted the lowest mental allowance rate for a State in the Region was 33% in 2001 and this went up to 40% in 2004. During this same time span, the highest mental allowance rate for a State in the Region stayed around 52%. This means the range between the Dallas DDSs decreased significantly between 2001 and 2004. He noted the lowest musculoskeletal allowance rate for a State in the Region rose from 14% in 2001 to19% in 2004.

Mr. Berling also explained that the sample accuracy rate for the FQA reviews has an error range of 3%. This means that if we reviewed every case in DDS and found an accuracy rate is of 94%, then 95% of the time the FQA sample accuracy would be plus or minus 3%, or between 91-97%.

Mr. Berling gave us a lot to think about when it comes to measuring quality and accuracy in the disability program. But, he gave me another thought as well. It occurred to me that with that experience as editor of the NADE Advocate, we know where to go if TADE ever needs a new editor for the TADE Times.

Southwest/Pacific Bi-Regional Conference, continued from page 28

Medical Vocational Analysis

by Bill Dunn, Texas DDS

Keith Odom, a Social Insurance Specialist with the SSA Regional Office in Dallas, gave a presentation on SSA Vocational Analysis policy at the 2005 SWADE/PADE Bi-regional Conference in Oklahoma City. He divided his presentation into different areas: a vocational policy update, occcupational statistics, and areas of rapid employment growth. He noted there are three things coming of interest vocationally. The first is Social Security Ruling (SSR) 05-02 on Unsuccessful Work Attempts which allows us to disregard brief periods of SGA done in the remote past. SSR 05-01C is based on Thomas vs. Barnhart and says we don't have to show availability of past work at Step 4 in Sequential Evaluation. Finally, Emergency Message (EM) 05012 on Borderline Age situations takes the old Disability Digest guidance and puts it into policy.

He then went into a list of things that *aren't happening*. First, there is no solution in sight to the Dictionary of Occupational Titles (DOT) crisis. SSA is trying to find someone to do a replacement to the DOT but there is no adequate replacement in sight at the moment. Next, there is no progress on the Notice of Proposed Rulemaking (NPRM) involving the issue of illiteracy/inability to communicate in English. This was first sent out for comments in 2003 but the final product will not be coming out any time soon. Next, the proposal to reduce the relevant work period is dead in the water. It was decided it would be too costly to implement. The proposal to permit bypassing step 4 in obvious step 5 denials is also dead as is the proposal to limit borderline age deeming to 4 months (instead of the current 6).

Mr. Odom provided some statistics about the occupational base using Bureau of Labor Statistics (BLS) data. He talked about three different groups; Multiple Job Holders, Persons Not in the Workforce, and Characteristics of Minimum Wage Workers. He noted that the BLS sorted Multiple Job Holders by age and found there were:

274,000 between the ages
of 16-19 years old,
795,000 between 20-24 years old,
5,361,000 between 25-54 years old,
and 869,000 over age 54.

When the BLS sorted persons not in the workforce by age group, they found:

14,151,000 from age 16-24 years,
21,288,000 from age 25-54 years,
and 40,517,000 over age 54 years.

Mr. Odom shared quite a bit of information about minimum wage workers. He noted that the BLS found 545,000 people paid exactly $5.15 and 1.6 million paid below this. Over half of those paid below minimum wage were below age 25. The education level of these 2.1 million people broke down as 620,000 having less than a high school education, 617,000 having a high school diploma, 700,000 having some college but no degree, and 163,000 having a college degree. Over 1.5 million of these jobs are in service occupations such as food preparation and service, personal care, building grounds keeping and cleaning, and health care. 287,000 are in sales and office jobs. 132, 000 are in jobs in the production, transportation, and materials handling industries. There are 95,000 in management and professional jobs and even less than that in the construction industry. The South has the most minimum wage workers with 42.3% (with 16.5%) coming from all the states of the SWADE region except New Mexico) and the West has the fewest at 12.1%. The Northeast has 19.6% and the Midwest has 26%.

Mr. Odom completed his presentation by informing us on the fastest growing areas of employment. He noted that the health service industry is expected to grow the most, especially such jobs as Medical Assistant, Home Health Aide, Physician Assistant, Social and Human Services Assistant, and Medical Records Technician. The computer industry is next, especially such jobs as Network Systems and Data Communication Specialists and Software Engineers. The education industry is next with such jobs as Fitness Trainers and Post Secondary Teachers and Vocational Trainers. Then, came the therapy occupations like Physical Therapist and Occupational Therapist.

Unfortunately, Mr. Odom ran out of time before he ran out of information. But as usual, he gave us a lot of information to think about.

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Coverage of the Great Lakes Regional Conference
by Ione Klima, Minnesota DDS

ENLIGHTENING: All About Winter Seasonal Depression

Presented by Michael DeSanctis, PhD, LP, ABPP at the Great Lakes Regional Training Conference, Springfield, IL, May, 2005

We are at risk for reduced cognitive efficiency, increased disruption in our sleep/wake cycle, carbohydrate loading as medication and isolation from the community. Why, you ask? Because we are not presently allowing for seasonal variations in our lives.

Dr. DeSanctis, psychological consultant in the MN DDS, had words to the wise for all of us about the rhythms of our lives, and particularly those of us from the more northerly climes that are familiar with the "cabin fever" syndrome of long and dark winters.

The requirements of rapid changes and pace of today may mean that our bodies and minds don't adapt particularly well and give us symptoms not known in earlier evolutionary times. We become exhausted from not listening to the time patterns of our environment. We enter a pattern of "learn, resist, exhaust." Our systems become vulnerable to physical illnesses, immune system compromise and depression.

ENTER SEASONAL AFFECTIVE DISORDER (SAD)

SAD is related to this lack of light. Humans have adapted by observing many customs related to the advent of the season of darkness, such as lighting up at Halloween (coming darkness), eating at Thanksgiving (carbo-loading for hibernation) and lighting up at Christmas or a related holiday (mid-winter, ending of winter).

Summer disorders are less well studied, they may relate to response to thermal stress, and symptoms are decreased appetite, weight loss and agitation. The further south one looks, the more symptoms of summer SAD one finds.

There are mild versions of SAD, time shows whether the definition of the severe type is met. The prevalence of the disorder increases with latitude (although there may be no more of it in the Arctic than in the mid-latitudes), and females appear to be at greater risk.

CLINICAL DEFINITION OF SAD

DISM IV criteria define it as a further specification of Major Depressive Disorder or Bi-Polar Affective Disorder (BPAD) with regular temporal relationship between onset of depressive episodes and particular time of year with full remissions or change from depression to mania also occurring at a particular time of year.

In other words, SAD is a variation of low energy in dark seasons and high energy in light seasons. This definition is further refined by referral to episodes in the past two years and over the course of a lifetime.

Some signs of SAD may sound familiar to northerners: excessive carbohydrate consumption during fall and winter; hypersomnolence and difficulty awakening; forgetfulness; slowed thinking or a sense of being in fog; low energy.

While the exact etiology is unknown, there are genetic and hormonal components. There is a relationship to melatonin — from the pineal gland, and produced when there is less light. We may really confuse our systems if our sleep cycle is off and therefore we absorb even *less* daylight than usual.

Seasonality exists in the population, but only a modest percentage meet clinical criteria for SAD, said DeSanctis. Duration is an obvious issue in disability evaluation. Winter SAD can produce severe limitations in stress tolerance, social adaptation and persistence/pace.

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