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SOCIAL SECURITY ADMINISTRATION

20 CFR Parts 404 and 416

[Docket No. SSA–2012–0035]

RIN 0960–AH51

Revisions to Rules Regarding the Evaluation of Medical Evidence

AGENCY: Social Security Administration.
ACTION: Final rules.

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

DATES: These final rules are effective on March 27, 2017.

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

SUPPLEMENTARY INFORMATION:

Background

We are revising and making final the rules regarding the evaluation of medical evidence that we proposed in a notice of proposed rulemaking (NPRM) published in the **Federal Register** on September 9, 2016 (81 FR 62560). In the preamble to the NPRM, we discussed the revisions we proposed and the bases for the proposals. To the extent that we are adopting those revisions as we proposed them, we are not repeating that information here. Interested readers may refer to the preamble to the NPRM, available at *http://www.regulations.gov* by searching for document number SSA–2012–0035–0001.

To help clarify which regulation sections we refer to in this preamble, we refer to the regulation sections in effect on the date of publication as the ''current'' regulation sections. We refer to the regulation sections that we proposed as the ''proposed'' regulation sections. We refer to the regulation sections that will be in effect as of the effective date of these final rules as the ''final'' regulation sections. The current, proposed, and final regulation sections refer to regulation sections in Title 20 of the Code of Federal Regulations.

Based on our adjudicative experience, legal precedents,[1] recommendations from the Administrative Conference of the United States (ACUS), and public comments we received on the NPRM, we are revising our rules to ensure that they reflect modern healthcare delivery and are easier to understand and use. We expect that these changes will help us continue to ensure a high level of accuracy in our determinations and decisions. We also are revising related rules about who can be an MC and a PC in conformity with requirements in the BBA.

The following list summarizes the differences in these final rules from what we proposed in the NPRM:

1. We revised the definitions of ''signs'' and ''laboratory findings'' to clarify that ''one or more'' signs, ''one or more'' laboratory findings, or both constitute objective medical evidence in final 404.1502 and 416.902.

2. We revised the proposed regulatory text for AMS optometrists in final 404.1502 and 416.902 to refer to the scope of practice in the State in which the optometrist practices.

3. We revised the proposed regulatory text for AMS audiologists in final 404.1502 and 416.902 to state that licensed audiologists are AMSs for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only.

4. We recognized physician assistants as AMSs for claims filed on or after March 27, 2017, in final 404.1502 and 416.902.

5. We revised the title and definition of the category of ''evidence from nonmedical sources'' in final 404.1513 and 416.913. We changed the title from ''statements from nonmedical sources'' as proposed to ''evidence from nonmedical sources'' for clarity. We revised the definition for brevity and to explain that we may receive evidence from nonmedical sources either directly from the nonmedical source or indirectly, such as from forms and our administrative records.

6. We clarified that a statement(s) about whether or not an individual has a severe impairment(s) is a statement on an issue reserved to the Commissioner in final 404.1520b(c)(3) and 416.920b(c)(3).

7. We revised final 404.1520c(a)–(b) and 416.920c(a)–(b) to clarify that, while we consider all evidence we receive, we have specific articulation requirements about how we consider medical opinions and prior administrative medical findings.

8. For claims filed on or after March 27, 2017, we are revising our rules to state that our adjudicators will articulate how they consider medical opinions from all medical sources, regardless of whether or not the medical source is an AMS, in final 404.1520c and 416.920c.

9. We revised the factors for considering medical opinions and prior administrative medical findings in final 404.1520c and 416.920c to both emphasize that there is not an inherent persuasiveness to evidence from MCs, PCs, or CE sources over an individual's own medical source(s), and vice versa, and to highlight that we continue to consider a medical source's longstanding treatment relationship with the individual.

10. We added regulatory text in final 404.1520c(d) and 416.920c(d) for claims filed on or after March 27, 2017, that there is no requirement to articulate how we considered evidence from nonmedical sources about an individual's functional abilities and limitations using the rules for considering and articulating our consideration of medical opinions found in final 404.1520c and 416.920c.

11. We clarified the section headings and introductory text in final 404.1520c, 404.1527, 416.920c, and 416.927 about the implementation process.

12. We added regulatory text in final 404.1527(f) and 416.927(f) for claims filed before March 27, 2017, about how we consider and articulate our consideration of opinions from medical sources who are not AMSs, and from nonmedical sources. We are adding our current policies found in SSR 06–03p, which explains how we consider and when we articulate our consideration of opinions from medical sources who are not AMSs and from nonmedical sources

[1] As we explained in the preamble to our NPRM, courts in most circuits typically remand claims to us for further adjudication when they find we erred by not giving controlling weight to treating source opinions; however, the Ninth Circuit uses a ''credit-as-true'' rule, which sometimes results in it ordering us to award benefits instead of remanding cases. 81 FR 62560, 62573.

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under our current rules, into the final rules for these claims.

13. We revised the criteria for which audiologists may perform audiometric testing in sections 2.00B and 102.00B of the Listings [2] to be consistent with our revision to recognize licensed audiologists as AMSs. We now state that audiometric testing must be performed by, or under the direct supervision of, a licensed audiologist or otolaryngologist.

14. We did not adopt our proposal to recognize independently practicing psychologists with master's-level education as qualified to be PCs. Instead, we will continue to follow our current policies about who is qualified to be a PC, which generally require a doctorate-level education degree, in final 404.1616 and 416.1016.

15. We made a number of nonsubstantive revisions relating to the revisions listed above, as part of our effort to reorganize our regulations for ease of use, to use consistent terminology throughout our rules, to reflect revisions to regulatory text made by other rules since publication of the NPRM, and for clarity.

Because of these revisions, these final rules retain only two programmatic distinctions between AMSs and medical sources who are not AMSs in our regulations for claims filed on or after March 27, 2017. First, we need objective medical evidence from an AMS to establish the existence of a medically determinable impairment(s) at step 2 of the sequential evaluation process.[3] Second, in a few instances, we need specific evidence from an AMS to establish that an individual's impairment meets a Listing.[4]

Effect on Certain Social Security Rulings (SSR)

We will also rescind the following SSRs that are otherwise inconsistent with or duplicative of these final rules:

- SSR 96–2p: Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions.[5]
- SSR 96–5p: Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner.[6]
- SSR 96–6p: Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence.[7]
- SSR 06–03p: Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not ''Acceptable Medical Sources'' in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies.[8]

In addition, because we will rescind SSR 96–6p, we will publish a new SSR that will discuss certain aspects of how administrative law judges (ALJ) and the Appeals Council (AC) must obtain evidence sufficient to make a finding of medical equivalence.

Public Comments

We received 383 comments on the NPRM, which are available for public viewing at *http://www.regulations.gov.* These comments were from:

- Individual citizens and claimant representatives;
- Members of Congress;
- Various professional organizations, such as the American Speech-Language Hearing Association (ASHA), American Psychological Association Practice Organization, American Academy of Family Physicians, American Academy of Pediatrics, American Optometric Association, and the American Association for Justice;
- National groups representing claimant representatives, such as the National Organization of Social Security Claimants' Representatives, the National Coalition of Social Security and SSI Advocates, and the National Association of Disability Representatives;
- Advocacy groups, such as the Consortium for Citizens with Disabilities, The Arc, the Community Legal Services of Philadelphia, and the North Carolina Coalition to End Homelessness; and
- Organizations representing our employees and employees of State agencies, such as the National Council of Disability Determination Directors, National Association of Disability Examiners, and the Association of Administrative Law Judges.

While we received several public comments in support of our proposed rules, we received many public comments that opposed our proposed revisions and that suggested alternative solutions to the policy changes we proposed. Among the most common concerns that the public comments raised were that:

- We should recognize additional medical sources as AMSs;
- The NPRM appeared to favor evidence from MCs, PCs, and consultative examination (CE) providers over evidence from an individual's own medical sources;
- We should continue to value or emphasize the individual's relationship with a treating source, including giving controlling weight to the medical source statements of treating sources in certain situations; and
- We should provide written analysis about medical opinions from all of an individual's own medical sources, regardless of whether the medical source is an AMS.

We carefully considered the comments. We strive to have clear and fair rules because our adjudicative process is non-adversarial.[9] To help maintain the fairness of our rules and our administrative review process, we have made several revisions in these final rules.

We discuss below the significant comments we received. Because some of the comments were long, we have condensed, summarized, and paraphrased them. We have tried to summarize the commenters' views accurately, and to respond to the significant issues raised by the commenters that were within the scope of the NPRM.

Sections 404.1502 and 416.902—Definitions for This Subpart

Comment: We received several comments about our proposal to recognize Advanced Practice Registered Nurses (APRN) as acceptable medical sources (AMS). While most of these commenters supported our proposal, a few commenters said that APRN qualifications were not equivalent to those of physicians, who are AMSs. Another commenter asked us to specify in the regulatory text that APRNs include Nurse Practitioners (NP) to reduce confusion.

Response: We agree with the comments that supported our proposal to recognize APRNs as AMSs for purposes of our programs. Although APRNs are not physicians, including APRNs as AMSs reflects the modern primary healthcare delivery system, including how healthcare is delivered in many rural areas.[10] In addition, the Institute of Medicine recommended Federal agencies recognize the advanced level of care provided by APRNs.[11]

[2] Part 404 Subpart P Appendix 1.

[3] See 42 U.S.C. 423(d)(3) and 1382c(a)(3)(D).

[4] See, for example, our rules for xeroderma pigmentosum in Listings 8.07A and 108.07A.

[5] 61 FR 34490 (July 2, 1996).

[6] 61 FR 34471 (July 2, 1996).

[7] 61 FR 34466 (July 2, 1996).

[9] Current 404.900(b) and 416.1400(b).

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

[11] Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at

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Furthermore, State licensure requirements for APRNs are rigorous. To receive APRN licensure, all States require these medical sources to be registered nurses and to have earned advanced nursing educational degrees. In addition, nearly all States require APRNs to obtain and maintain national certification by a standard advanced nursing credentialing agency,[12] and this certification requires extensive education and training.[13] Despite minor variability in names and licensure requirements, a growing number of States are adopting the Consensus Model for APRN Regulation from the American Association of Nurse Practitioners, which defines the standards for licensure, accreditation, certification, education, and practice.[14]

While we appreciate the suggestion to specify in our rules that APRNs include NPs, we did not adopt it. As we stated in the preamble to the NPRM,[15] APRNs include four types of medical sources: Certified Nurse Midwife, NP, Certified Registered Nurse Anesthetist, and Clinical Nurse Specialist. Although the majority of States use the APRN title, a minority of States use other similar titles, such as Advanced Practice Nurse and Advanced Registered Nurse Practitioner. We will maintain a current list of State-specific AMS titles in our subregulatory instructions to help our adjudicators identify the appropriate titles for APRNs.

Comment: Several commenters supported our proposal to include audiologists as AMSs. One commenter also supported the addition of audiologists as providers who could perform the otologic examination in order to establish the medically determinable impairment that causes hearing loss. Another commenter asked us to recognize that audiologists' scope of practice includes impairments of balance disturbance.

Response: We agree with these commenters. We included audiologists as AMSs and allow use of licensed audiologist-performed otologic examinations under Listings 2.00 and 102.00 in these final rules.

We also revised the final regulatory text to recognize that audiologists' scope of practice generally includes evaluation, examination, and treatment of certain balance impairments that result from the audio-vestibular system. However, some impairments involving balance involve several different body systems that are outside the scope of practice for audiologists, such as those involving muscles, bones, joints, vision, nerves, heart, and blood vessels. Therefore, we revised final 404.1502 and 416.902 to state that licensed audiologists are AMSs for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only.

Comment: Two commenters asked us to recognize audiologists as AMSs if they did not have State licensure but did have certification from the American Board of Audiology (ABA) or a Certificate of Clinical Competence in Audiology (CCC–A) from ASHA.

Response: We did not accept this comment because our existing practice has been to rely on State professional education and licensure requirements that are largely consistent with each other when we have expanded the AMS list.[16] While we appreciate the background provided by the commenter, we do not find it contained persuasive rationale about why we should be able to use evidence from these unlicensed sources to help establish the existence of hearing loss, auditory processing disorders, or balance disorders. Moreover, an audiologist without a valid State license will not qualify as a medical source under final sections 404.1502(d) and 416.902(i).

Comment: The American Optometric Association suggested that we modify our AMS definition of optometrists to refer to the scope of practice as authorized by State licensure. By simply stating that doctors of optometry can serve as an AMS according to their State's scope of practice laws, we would not need to go through the rulemaking process to change our regulations if a State chooses to change its scope of practice laws in the future.

Response: We agree with this comment, and we revised the final regulatory text about optometrists as AMSs. Specifically, we revised the proposed regulatory text for AMS optometrists in final 404.1502 and 416.902 to read, ''Licensed optometrist for impairments of visual disorders, or measurement of visual acuity and visual fields only, depending on the scope of practice in the State in which the optometrist practices.''

Comment: We received comments from several commenters, including the American Association of Physician Assistants, recommending that we add physician assistants (PA) to the AMS list. These commenters supported this recommendation by stating that PAs receive extensive medical education (approximately 27 months), have at least 2,000 hours of supervised clinical practice, are recognized as primary care providers, and must pass the Physician Assistant National Certifying Examination (PANCE).

Response: We are adopting this comment and recognizing PAs as AMSs. We agree that health care delivery continues to change and that PAs have an important and growing role as primary and specialty health care providers in many different health care settings. We agree that PAs receive extensive medical education, clinical experience, and pass the rigorous PANCE. Almost all States now require PAs to have at least a masters-level education, with the master's education level set to become the universal requirement in the near future.[17]

Consistent with our implementation process discussed more fully in the NPRM and below, we will recognize PAs as AMSs for claims filed on or after March 27, 2017, as we are doing for APRNs and audiologists.

Comment: We received many other public comments on the criteria we should use to add AMSs and whether we should add other medical sources, such as licensed clinical social workers (LCSW), to the AMS list. Most of these commenters supported recognizing LCSWs as AMSs, and they suggested we also add a wide variety of other medical sources and nonmedical sources,

the Institute of Medicine; Institute of Medicine: The Future of Nursing: Leading Change, Advancing Health (2011), available at *http://www.nationalacademies.org/hmd/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health/Report-Brief-Scope-of-Practice.aspx.*

[12] In a very few States, the advanced nursing credentialing is optional. These are: (1) California for Nurse Practitioners, see Cal.C.Reg. 16.8.1482, available at *http://www.rn.ca.gov/pdfs/regulations/bp2834-r.pdf;* (2) Indiana for Nurse Practitioners and Clinical Nurse Specialists, see Indiana's Administrative Code 848 IAC 4–1–4 and –5, available at *http://www.in.gov/pla/files/ISBN.2011_EDITION.pdf;* (3) New York, see Education Law Article 139 § 6910 for Nurse Practitioners and Clinical Nurse Specialists, available at *http://www.op.nysed.gov/prof/nurse/article139.htm,* and Article 140 § 79–5.2 for Midwives, available at *http://www.op.nysed.gov/prof/midwife/part79-5.htm;* and 4) Oregon for Clinical Nurse Specialists, see Oregon Rules 851–054–0040, available at *http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_851/851_054.html.*

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

[14] See National Council of State Boards of Nursing Campaign for Consensus, available at *https://www.ncsbn.org/738.htm,* and the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, available at *http://www.aacn.nche.edu/education-resources/APRNReport.pdf.*

[15] 81 FR at 62568.

[16] The only exception has been for speech-language pathologists who meet certain certification requirements. See current 404.1513(a)(5) and 416.913(a)(5).

[17] See the *Accreditation Standards for Physician Assistant Education, Fourth Edition,* available at: *http://www.arc-pa.org/wp-content/uploads/2016/10/Standards-4th-Ed-March-2016.pdf.*

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including licensed marriage and family therapists (LMFT), registered nurses (RN), licensed professional counselors (LPC), physical therapists (PT), chiropractors, and even healthcare professionals without medical licensure.

Response: We value these comments, and we will continue to monitor licensure requirements for the medical sources the commenters suggested that we add. At this time, however, we have decided to add only APRNs, audiologists, and PAs as AMSs. Upon investigation of licensing requirements for other medical sources, we did not find a similar level of consistency or rigor in terms of education, training, certification, and scope of practice.

Many of the comments that asked us to expand the AMS list to these additional medical sources said we should recognize these medical sources as AMSs so we could begin to consider their evidence in our adjudicative process. However, as we stated in the NPRM, we currently consider all relevant evidence we receive from all medical sources regardless of AMS status. However, as we noted above, we need objective medical evidence from an AMS to establish that an individual has a medically determinable impairment, as required by the Social Security Act (Act).

Additionally, many comments focused upon the prevalence of these sources in the healthcare system, particularly for individuals who have mental impairments, are poor, or are experiencing homelessness. Comments that did address licensing requirements, training, and education for these medical sources did not demonstrate that they have sufficiently consistent and rigorous national licensing requirements for education, training, certification, and scope of practice that is equivalent to the current and final list of AMSs.

For RNs, licensure typically can be obtained with education at or below the bachelor's degree level.[18] This is contrast to the current and new AMSs, for whom more rigorous education, training, and credentialing requirements are necessary.

For LCSWs, LPCs, LMFTs, PTs, and chiropractors, States significantly vary on titles, the required hours of experience for licensure, and the scope of practice, such as clinical and non-clinical practice. Our current and new AMSs have licensure requirements that are more nationally consistent, which is essential for us to administer a national disability program.[19]

As to the comments that asked us to recognize nonmedical sources as AMSs, our rules require an AMS to be a ''medical source'' as defined in 404.1502 and 416.902. Therefore, we did not adopt those suggestions.

Although we will not recognize the additional suggested medical sources as AMSs at this time, we will continue to consider evidence from these medical sources under these final rules when we evaluate the severity of an individual's impairment(s) and its effect on the individual.

Comment: One commenter agreed with our proposed definition of ''medical source'' in proposed 404.1502 and 416.902. The commenter said including licensure and certification requirements as specified by State or Federal law would help to ensure that medical sources who provide evidence to us are qualified and practicing lawfully. Another commenter asked us to recognize an entire medical practice as a medical source instead of its individual providers because some individuals receive treatment from multiple medical sources employed by the same medical practice.

Response: We agree with the first comment, and we are adopting our proposed definition of ''medical source'' in these final rules. However, we did not adopt the second comment because a medical source is an individual, not an entity, under our current rules.[20] Although we request evidence from medical practices, an entire practice itself is not capable of evaluating, examining, or treating an individual's impairments. A medical practice would not be able to perform a consultative examination at our request, or provide a medical opinion about an individual's functional abilities or limitations. Ultimately, individual medical practitioners and not their employing entities perform these functions. For these reasons, we did not adopt the recommendation to recognize an entire medical practice as a medical source.

Comment: Several commenters opposed our proposal to remove the term ''treating source'' from our regulations. One commenter opposed our proposal to recognize all of the medical sources that an individual identifies as his or her medical source instead of using the term ''treating source'' for AMSs as defined in our current rules.

Response: While we acknowledge the importance of the relationship between an individual and his or her own medical sources, we are adopting our proposed regulatory text in these final rules. As part of our revisions to align our rules with how individuals now receive healthcare, it is appropriate to remove the distinction between a ''treating source''—who must be an AMS—and the other medical sources from whom an individual may choose to receive evaluation, examination, or treatment. This will allow us to select an individual's own medical source, regardless of AMS status, to be a preferred source to conduct a consultative examination (CE) if the medical source meets our other requirements for CE sources in final 404.1519h and 416.919h.

Comment: One commenter requested that we specify that licensed mental health care providers who are working within the scope of practice permitted by law are a type of healthcare worker, and therefore a medical source. Another commenter was concerned that the proposed regulatory definition of nonmedical source would cause confusion when a licensed mental healthcare provider works at a homeless shelter or social service agency instead of a medical practice.

Response: We agree that the definition of medical source includes licensed mental health care providers working within the scope of practice permitted by law. The definition of medical source in final 404.1502 and 416.902 is sufficiently broad to include licensed mental health care providers without the need to amend the regulatory definition. We do not consider the employer of a source to determine whether a source is a medical source. Instead, we look to whether the source meets the definition of a medical source. Part of our final definition of a ''medical source'' is that the source is working within the licensed scope of his or her practice. Therefore, when an individual is licensed as a healthcare worker by a State and is working within the scope of his or her practice under State or Federal law, we will consider the source to be a medical source.

Comment: Some commenters raised concern about the language in proposed sections 404.1502 and 416.902 that define ''objective medical evidence'' as ''signs, laboratory findings, or both.'' The commenters indicated that the proposed language appeared to state a new requirement that would make it ''extremely difficult'' to establish the existence of mental impairments and

[18] See Bureau of Labor Statistics Occupational Outlook Handbook: ''Registered Nurses'', available at *http://www.bls.gov/ooh/Healthcare/Registered-nurses.htm,* and American Nurses Association, available at *http://www.nursingworld.org/EspeciallyForYou/What-is-Nursing/Tools-You-Need/RegisteredNurseLicensing.html.*

[19] For example, all physicians, optometrists, and podiatrists have doctorate degrees.

[20] See, for example, current 404.1513(d) and 416.913(d).

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impairments related to migraine headaches. The commenters suggested that we also consider a person's diagnosis, statement of symptoms, and medical source opinions to establish the existence of an impairment. One commenter thought the exclusion of symptoms from ''objective medical evidence'' conflicted with our recent final rules ''Revised Medical Criteria for Evaluating Mental Disorders.'' [21] Those final rules include references to symptoms of mental impairments in the introductory text and criteria of the mental disorders listings.

Response: We understand the commenter's concerns that we should not disadvantage individuals with mental and headache-related impairments, and these clarifications of our current policy will not change how we establish these medically determinable impairments.

The proposed definition of objective medical evidence in proposed 404.1502(f) and 416.902(k) is consistent with our current rules. We currently define objective medical evidence as signs *and* laboratory findings.[22] To clarify our current policy, we redefine objective medical evidence as signs, laboratory findings, or both to make clear that signs alone *or* laboratory findings alone are objective medical evidence.

Our current rules require objective medical evidence consisting of signs or laboratory findings to establish impairments, including mental and headache-related impairments.[23] Current 404.1508 and 416.908 states that ''[a] physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by your statement of symptoms.'' Thus, even under our current rules, mental and headache-related impairments must be established by objective medical evidence. These final rules merely clarify this current policy.

Another current policy that we are clarifying in the definition of ''signs'' in these final rules is that one or more medically demonstrable phenomena that indicate specific psychological abnormalities that can be observed, apart from your statements, such as abnormalities of behavior, mood, thought, memory, orientation, development, or perception, can be ''signs'' that establish a medically determinable impairment. Additionally, psychological test results are laboratory findings that may establish medically determinable cognitive impairments.

Once we establish the existence of an impairment, we use evidence from all sources to determine the severity of the impairment and make the appropriate findings in the sequential evaluation process, such as whether an impairment meets the criteria of a Listing. This includes statements of symptoms, diagnoses, prognoses, and medical opinions.

Our recent final rules ''Revised Medical Criteria for Evaluating Mental Disorders'' discuss an individual's symptoms in the context of our assessments of the *severity* of a mental impairment and whether the mental impairment satisfies the listing criteria. However, we make these assessments *after* we determine that objective medical evidence establishes the existence of the mental impairment. Under our current rules, the proposed rules, and these final rules, an individual's statement of his or her symptoms cannot establish the existence of an impairment.

Sections 404.1504 and 416.904—Decisions by Other Governmental Agencies and Nongovernmental Entities

Comment: While a few commenters agreed with our proposal not to provide analysis about decisions by other governmental agencies and nongovernmental entities in our decisions and determinations, other commenters disagreed that those decisions are inherently neither valuable nor persuasive. Some commenters stated these decisions are important evidence that we should always discuss because the rules or purposes of other disability programs are similar to our programs, while other commenters said we should discuss the decisions because they may be more or less probative to our decisionmaking due to the different standards used. Some commenters suggested we provide additional training to our adjudicators about the standards used by other governmental agencies and nongovernmental entities. Other commenters asserted that the Department of Veterans Affairs (VA) 100% disability ratings and Individual Unemployability (IU) ratings are highly probative to our decisionmaking by pointing to our own research showing veterans are substantially more likely to be found disabled than the general population of applicants. A few commenters said we should adopt a VA 100% disability rating or have a rebuttable presumption that someone with a VA disability rating is entitled to disability under the Act.

Response: While we acknowledge the commenters' concerns, we are adopting our proposal in these final rules.

As we stated in the notice of proposed rulemaking (NPRM), there are four reasons why we are not requiring our adjudicators to explain their consideration of these decisions—(1) the Act's purpose and specific eligibility requirements for disability and blindness differ significantly from the purpose and eligibility requirements of other programs; (2) the other agency or entity's decision may not be in the record or may not include any explanation of how the decision was made, or what standards applied in making the decision; (3) our adjudicators generally do not have a detailed understanding of the rules other agencies or entities apply to make their decisions; and (4) over time Federal courts have interpreted and applied our rules and Social Security Ruling (SSR) 06–03p differently in different jurisdictions.[24]

Although we are not requiring adjudicators to provide written analysis about how they consider the decisions from other governmental agencies and nongovernmental entities, we do agree with the commenters that underlying evidence that other governmental agencies and nongovernmental entities use to support their decisions may be probative of whether an individual is disabled or blind under the Act. In sections 404.1504 and 416.904 of the proposed rules, we provided that we would consider in our determination or decision the relevant supporting evidence underlying the other governmental agency or nongovernmental entity's decision that we receive as evidence in a claim. We clarify in final 404.1504 and 416.904 that we will consider all of the supporting evidence underlying the decision from another government agency or nongovernmental entity decision that we receive as evidence in accordance with final 404.1513(a)(1)–(4) and 416.913(a)(1)–(4).

We are not adopting the suggestion that we should train our adjudicators on the various standards of other governmental agencies and nongovernmental entities that make disability or blindness decisions. Even with increased training, the actual decision reached under different standards is inherently neither valuable nor persuasive to determine whether an individual is disabled or blind under the requirements in the Act, for the

[21] 81 FR 66137 (Sept. 26, 2016).

[22] Current 404.1512(b)(1)(i) and 416.912(b)(1)(i), as defined in current 404.1528(b)–(c) and 416.928(b)–(c).

[23] See current 404.1508 and 416.908, as published on August 20, 1980 at 45 FR 55584, pp. 55586 and 55623.

[24] 81 FR at 62564–65.

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reasons we discussed in the preamble to the NPRM.[25]

Furthermore, while we did not rely on the research cited in a few comments to propose these rules, upon review of that research,[26] we disagree with the commenters' summary of it. Specifically, our researchers studied the interaction of our rules and the VA's disability standards, focusing upon VA 100% disability ratings and IU ratings. They concluded VA and SSA disability programs serve different purposes for populations that overlap. While individuals with a VA rating of 100% or IU have a slightly higher allowance rate under our programs than members of the general population, nearly one-third are denied benefits based on our rules for evaluating medical (or medical-vocational) considerations. This data also supports our conclusion that these ratings alone are neither inherently valuable nor persuasive in our disability evaluation because they give us little substantive information to consider. Fortunately, the VA and the Department of Defense (DoD) share medical records electronically with us, and our adjudicators obtain the medical evidence documenting DoD and VA treatment and evaluations to evaluate these claims.

Comment: Two commenters asked whether individuals and their representatives would need to submit evidence of a disability, blindness, or employability decision by another governmental agency or nongovernmental entity to us because our rules would state these decisions are inherently neither valuable nor persuasive to us.

Response: We appreciate the opportunity to clarify this matter. Under current and final 404.1512(a) and 416.912(a), an individual must inform us about or submit all evidence known to him or her that relates to whether or not he or she is blind or disabled. Similarly, under current 404.1740(b)(1) and 416.1540(b)(1), an appointed representative must act with reasonable promptness to help obtain the information or evidence that the individual must submit under our regulations, and forward the information or evidence to us for consideration as soon as practicable. A disability, blindness, or employability decision by another government agency or nongovernmental entity may not relate to whether or not an individual is blind or disabled under our rules. Nevertheless, as explained above, our adjudicators will consider the relevant supporting evidence underlying the other governmental agency or nongovernmental entity's decision. When an individual informs us about another government agency's or nongovernmental entity's decision, we will identify and consider, or will assist in developing, the supporting evidence that the other agency or entity used to make its decision. We may also use that evidence to expedite processing of claims for Wounded Warriors and for veterans with a 100% disability compensation rating, as we do under our current procedures.[27]

Sections 404.1512 and 416.912—Responsibility for Evidence

Comment: We received one comment about the regulatory text in proposed 404.1512(a)(2) and 416.912(a)(2). The commenter asked us to revise this rule to require our adjudicators to develop evidence from the time before an individual's date last insured[28] through the date of our determination or decision, even when this date last insured occurs many years earlier. The commenter also suggested that proposed 404.1512(a)(2) and 416.912(a)(2) could be inconsistent with the Act's requirement in 42 U.S.C. 423(d)(5)(A) that an individual has the burden to provide us with evidence sufficient to determine that he or she is under a disability.

Response: We did not adopt this comment because the regulatory text in proposed 404.1512(a)(2) and 416.912(a)(2) is identical to the current text in 404.1513(e) and 416.913(e). We proposed this language verbatim for proposed 404.1512(a)(2) and 416.912(a)(2) as part of our effort to reorganize our rules. We did not propose any substantive revision. An individual does have the burden to prove he or she is disabled, and this regulatory text is consistent with that requirement of the Act. Our current policies about how to develop a claim with a date last insured in the past are found in our subregulatory instructions.[29]

Comment: A few commenters asked us increase the 10 to 20 calendar day timeframe for medical sources to respond to our initial request for evidence in proposed 404.1512(b)(1)(i) and 416.912(b)(1)(i). Some commenters suggested different periods between 20 to 30 calendar days as a more reasonable time for medical sources to respond, and they suggested that a longer timeframe would reduce our costs associated with for consultative examinations (CE). Another commenter suggested we include five additional days for mailing time.

Response: While we appreciate these comments, we did not adopt them. When we develop evidence in a claim, we make every reasonable effort to get evidence from an individual's own medical sources. Under our current rules in 404.1512(d)(1) and 416.912(d)(1), this requirement includes giving medical sources 10 to 20 calendar days to respond to our initial request for evidence before we make a follow-up attempt. After the follow-up attempt, our regulations provide for an additional 10 days, for a minimum of at least 20 to 30 days in total. In our experience, our current rules provide an adequate amount of time to submit records because most medical sources provide the requested evidence within this period. Our current rules in 404.1512(e) and 416.912(e) generally require us to wait until after this period to request a CE, and the final rules in 404.1512(b)(2) and 416.912(b)(2) retain this requirement.

With the increasing use of electronic health records and electronic records transfer, we receive an increasing amount of medical evidence the same day that we request it. We are committed to expanding our electronic transfer capacity for medical records through ongoing expansion of the use of Health Information Technology. The expanded use of Health Information Technology means that we do not have an administrative need to make the change to the rules that the commenters suggested.

Sections 404.1513 and 416.913—Categories of Evidence

Comment: One commenter disagreed with our proposal to exclude ''symptoms, diagnosis, and prognosis''

[25] *Id.*

[26] Social Security Bulletin, Vol. 74, No. 3, 2014, p. 25. Veterans Who Apply for Social Security Disabled-Worker Benefits After Receiving a Department of Veterans Affairs Rating of ''Total Disability'' for Service-Connected Impairments: Characteristics and Outcomes. (by L. Scott Muller, Nancy Early, and Justin Ronca), available at *https://www.ssa.gov/policy/docs/ssb/v74n3/v74n3p1.pdf.*

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

[28] In order to be entitled to disability insurance benefits under title II of the Act, an individual must have, among other things, enough earnings in employment covered by Social Security to be insured for disability. See section 223(c)(1) of the Act, 42 U.S.C. 423(c)(1), and current 404.130 and 404.315(a). An individual's date last insured is the last date the individual is insured for purposes of establishing a period of disability or becoming entitled to disability insurance benefits, as determined under current 404.130.

[29] See POMS DI 25501.320 Date Last Insured (DLI) and the Established Onset Date (EOD), available at *https://secure.ssa.gov/apps10/poms.nsf/lnx/0425501320.*

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from the definition of ''medical opinion'' and instead categorize these as ''other medical evidence.'' The commenter expressed concern that most medical sources, unless prompted to fill out a functional questionnaire, do not specifically address functional abilities and limitations in their notes; rather, medical sources normally include symptoms, diagnoses, and prognoses. This commenter indicated that as a result, unrepresented individuals would be disadvantaged because they may not know to ask medical sources to complete the functional questionnaires. The commenter also said some medical sources refuse to fill out such forms or perhaps charge extra for completing the forms, which is outside the individual's control. This commenter asserted that without a form or letter from a medical source, we are more likely to schedule a consultative examination (CE) and to disregard the medical source's evidence in the hearing decision.

Response: We understand the concerns expressed in these comments; however, we did not adopt the recommendation to retain ''symptoms, diagnosis, and prognosis'' in the definition of ''medical opinions.'' Diagnoses and prognoses do not describe how an individual functions. It is also not appropriate to categorize symptoms as medical opinions because they are subjective statements made by the individual, not by a medical source, about his or her condition.

As for the commenter's concerns about the effect of these final rules on unrepresented individuals, our current practice is consistent with the Act's requirements that we make every reasonable effort to obtain evidence from all of an individual's medical sources.[30] We make every reasonable effort to develop evidence about an individual's complete medical history from the individual's own medical sources prior to evaluating medical evidence obtained from any other source on a consultative basis, regardless of whether the individual is represented or not.[31] Regardless of an individual's financial situation, diagnoses and prognoses do not describe how an individual functions and symptoms are subjective statements made by the individual, not a medical source, about his or her impairments.

Comment: One commenter supported the clarification in the proposed rules that all medical sources, not just acceptable medical sources (AMS), can provide evidence that we will categorize as being evidence from medical sources.

Response: We appreciate this comment, and we are adopting the clarification in these final rules.

Comment: A few commenters opposed our proposed category of evidence that we called ''statements from nonmedical sources'' in proposed 404.1513(a)(4) and 416.913(a)(4) because they wanted us to consider evidence from unlicensed staff who are part of social service agencies and public mental health systems separately from evidence from individuals, family members, and neighbors. Another commenter stated the proposed rule would threaten the functional assessment by eliminating the need for the adjudicator to explain how he or she considers functional evidence, particularly offered by nonmedical sources. A few commenters asserted this revision would disadvantage child claimants who have functional evidence from nonmedical sources, such as educators.

Response: We want to reassure these commenters that this proposal to use one category of evidence for these nonmedical sources, which we are adopting in these final rules, will not disadvantage individuals in our programs. We proposed the single category of evidence, which we renamed in these final rules as ''evidence from nonmedical sources,'' to reflect that there are no policy differences in how we consider this type of evidence. We agree that evidence from nonmedical sources who are part of social service agencies and public mental health systems may be valuable, and we consider this evidence. However, this evidence is not inherently more or less valuable than evidence from any other kind of nonmedical source, such as individuals, family members, and neighbors.

Sometimes, the individual, family members, and other nonmedical sources of evidence can provide helpful longitudinal evidence about how an impairment affects a person's functional abilities and limitations on a daily basis. In claims for child disability, we often receive functional evidence from nonmedical sources, such as testimony, evaluations, and reports from parents, teachers, special education coordinators, counselors, early intervention team members, developmental center workers, day care center workers, social workers, and public and private social welfare agency personnel. Depending on the unique evidence in each claim, it may be appropriate for an adjudicator to provide written analysis about how he or she considered evidence from nonmedical sources, particularly in claims for child disability.

Because we consider all evidence we receive, we are not adopting the suggestion to use separate categories of evidence for different kinds of nonmedical sources or for rules about which nonmedical sources' evidence is inherently more valuable than others' evidence.

Our adjudicators will continue to assess an individual's ability to function under these final rules using all evidence we receive from all sources, including nonmedical sources. Having one category of evidence instead of two for nonmedical sources will not affect our rules for assessing an individual's functional abilities.

In response to these and other public comments, both the title and definition of this category of evidence is different from that which we proposed. We decided to simplify, shorten, and clarify that this category of evidence includes any evidence from any nonmedical source that we receive, and that we may receive it in any manner.

For example, this category of evidence includes data from our administrative records about an individual's earnings history and information resulting from data matching with other government agencies that relates to any issue in a claim, such as birthdates and marriage history.

We list and define the categories of evidence in final 404.1513(a)(1)–(5) and 416.913(a)(1)–(5). The following chart displays the categories:

[30] 42 U.S.C. 423(d)(5)(B) and 1382c(a)(1)(H)(i).

[31] See, for example, POMS DI 22505.006 Requesting Evidence—General, available at *https://secure.ssa.gov/apps10/poms.nsf/lnx/0422505006.*

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

Sections 404.1519h and 416.9191h—Your Medical Source

Comment: Many commenters supported our proposal to broaden the preference for consultative examination (CE) sources from ''treating sources'' to any of an individual's own medical sources who are otherwise qualified to perform the CE.

Response: We agree with these comments. In order to perform a CE, an individual's medical source must be qualified, equipped and willing to perform the examination or tests for the designated payment and send in timely, complete reports. This aligns with the current requirements for all CE providers and does not significantly change our current process. If these standards are met, it is our preference to use an individual's own medical source to perform a CE.

Sections 404.1520b and 416.920b—How We Consider Evidence

Comment: One commenter opposed proposed 404.1520b(c)(2) and 416.920b(c)(2), under which we would not provide written analysis about disability examiner findings at subsequent adjudicative levels of appeal, as we do for prior administrative medical findings.

Response: Because this is our current policy, we did not adopt this comment. At each level of the administrative process, we conduct a new review of the evidence whenever we issue a new determination or decision. While some disability examiners now make some administrative medical findings at the initial and reconsideration levels under temporary legal authority, this authority is scheduled to end pursuant to the Bipartisan Budget Act of 2015 (BBA) section 832.[32]

Comment: A few commenters suggested that we continue the current practice of not giving any special significance to opinions on issues reserved to the Commissioner instead of adopting our proposal in 404.1520b(c)(3) and 416.920b(c)(3) that we not provide any analysis about how we consider statements on issues reserved to the Commissioner. These commenters also stated that the final rule should clarify that adjudicators will consider the context of a medical source's use of terms in our laws and regulations, such as ''moderate,'' ''marked,'' and ''sedentary.'' One commenter noted that the diagnostic term ''intellectual disability'' uses the word ''disability'' but is not a statement on an issue reserved to the Commissioner. These commenters cautioned against adjudicators dismissing medical opinions as issues reserved for the Commissioner simply because they use the same terms in our laws and regulations. The commenters suggested we include an example in our rules. Another commenter said we should not include ''statements that you are or are not . . . able to perform regular or continuing work'' as an example of a statement on an issue reserved to the Commissioner in proposed 404.1520b(c)(3) and 416.920b(c)(3) because it is probative about an individual's residual functional capacity (RFC).[33]

Response: We agree that adjudicators should consider the context of a source's use of a term in our laws and regulations to determine if it qualifies as a statement on an issue reserved to the Commissioner or another kind of evidence, such as a medical opinion. We frequently receive documents from medical sources that contain different categories of evidence, such as a treatment note that includes a laboratory finding, a medical opinion, and a statement on an issue reserved to the Commissioner. When we receive a document from a medical source that contains multiple categories of evidence, we will consider each kind of evidence according to its applicable rules. We will not consider an entire document to be a statement on an issue to the Commissioner simply because the document contains a statement on an issue that is reserved to the Commissioner. However, we are not revising our rules to add text about considering context or to provide examples because we intend to further clarify and provide examples, as appropriate, in our subregulatory instructions.

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

We are also not revising our rules to omit the phrase ''statements that you are or are not . . . able to perform regular or continuing work'' from final 404.1520b(c)(3) and 416.920b(c)(3). We are responsible for assessing an individual's RFC, including how our programmatic terms apply to evidence we receive.

Comment: One commenter asked us to state that when an administrative law judge (ALJ) asks a medical expert about whether an impairment(s) medically equals an impairment(s) in the Listings, that is a medical opinion and not a statement on an issue reserved to the Commissioner.

Response: Because we are not revising this current policy in these final rules, we are not adopting the comment. When a medical expert, or any other medical source, opines about whether an individual's impairment(s) medically equals an impairment(s) in the Listings, we consider that statement to be a statement on an issue reserved to the Commissioner under our current policy.

[32] See *Modifications to the Disability Determination Procedures; Extension of Testing of Some Disability Redesign Features,* 81 FR 58544 (August 25, 2016).

[33] See current 404.1545 and 416.945.

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For example, if we receive a medical report that contains a medical opinion and a statement on an issue reserved to the Commissioner, we will articulate how we considered the medical opinion according to its rules but not articulate how we considered the statement on an issue reserved to the Commissioner.

In addition, we will issue a new Social Security Ruling that will discuss certain aspects of how ALJs and the AC must obtain evidence sufficient to make a finding of medical equivalence.

Comment: One commenter opposed our terminology of a statement on an issue reserved to the Commissioner because it is ''reserved for the ALJ, not the Commissioner.''

Response: We did not adopt this comment. Whenever an adjudicator at any level of our administrative process makes a disability or blindness determination or decision, he or she is acting pursuant to authority delegated by the Commissioner.[34] Our adjudicators do not have authority independent of the authority given to them pursuant to a lawful delegation of authority.

Sections 404.1520c and 416.920c—How We Consider and Articulate Medical Opinions and Prior Administrative Medical Findings for Claims Filed on or After March 27, 2017

Prior Administrative Medical Findings

Comment: Two commenters had concerns about our policies for considering prior administrative findings, such as the severity of an individual's symptoms, failure to follow prescribed treatment, and drug addiction and alcoholism. The commenters stated that medical evidence should be provided solely by medical professionals and suggested that prior administrative medical findings are not made by medical sources.

Response: The three categories of evidence from medical sources and prior administrative medical findings must be made by medical sources. Prior administrative medical findings are made by medical sources who are State or Federal agency medical consultants or psychological consultants. This is our current policy in current 404.1527(e)(1) and 416.927(e)(1). Our rules in current 404.1527(e)(2) and 416.927(e)(2) require us to consider and articulate our consideration of prior administrative medical findings using the same factors we use to consider medical opinions.

Under section 221(h) of the Act, as amended by the Bipartisan Budget Act of 2015 (BBA) section 832, we are now required to make ''every reasonable effort'' to ensure that a qualified physician (in cases involving a physical impairment) or a qualified psychiatrist or psychologist (in cases involving a mental impairment) has completed the medical review of the case and any applicable residual functional capacity (RFC) assessment. In final 404.1520c, 404.1527, 416.920c, and 416.927, we explain in detail how will we consider and articulate our consideration of prior administrative medical findings.

Comment: One commenter asked us to consider opinions from the Appeals Council's (AC) Medical Support Staff (MSS) as prior administrative medical findings.

Response: Although our current policies allow adjudicators at the hearings and AC levels of review to obtain medical expert evidence, including MSS opinions at the AC, we did not adopt this comment for two reasons. First, expert medical opinions obtained at the same level of adjudication could not be a *prior* administrative medical finding. Second, medical expert evidence obtained at the hearings or AC levels does not amount to our own medical findings; instead, our adjudicators at these levels are responsible for determining whether an individual is disabled. They must consider expert medical opinions obtained at the same level under the standard for evaluating medical opinions.

Comment: A few commenters asked how our rules for considering prior administrative medical findings would apply to claims we decided previously, considering the legal principle of *res judicata,* which means an issue definitively settled by a prior determination or decision.

Response: We appreciate this comment, and we have revised the final rules to address this question. These final rules do not affect our current policies about *res judicata.* Prior administrative medical findings are evidence in the current claim. To help clarify this point, we have revised the prior administrative medical findings evidence category's definition in final 404.1513(a)(5) and 416.913(a)(5) to specify that this is a category of evidence in the current claim.

Comment: One commenter asserted that allowing administrative law judges (ALJ) to consider prior administrative medical findings means that individuals at the hearings level do not get a new and independent review of their claims. Another commenter raised concern that requiring State agency adjudicators to provide written analysis about the persuasiveness of the prior administrative medical findings from the initial level of review appeared to conflict with the principles of getting a new and independent review.

Response: We did not make any specific changes based on these comments. A *new* decision means that adjudicators at subsequent levels of the administrative review process (*i.e.,* reconsideration, hearing, and AC) do not need to defer to the findings or conclusions of prior adjudicators. Instead, they make new findings and conclusions. Currently, adjudicators at all levels of the administrative review process consider prior administrative medical findings as part of conducting a new and independent review when they issue a determination or decision.[35] Based on our experience administering our programs, we have found that our adjudicators reasonably consider prior administrative medical findings as part of the evidence in the claim and do not automatically favor or disfavor this evidence simply because the medical source is a medical consultant (MC) or a psychological consultant (PC).

Treating Source Rule

Comment: Multiple commenters asked us to retain the current treating source rule, while some commenters agreed with our proposal to eliminate it. Those who wanted us to retain the treating source rule said that evidence from a treating source has special intrinsic value due to the nature of the medical source's relationship with the claimant. They also said that the current rules contain an appropriate inherent hierarchy to give the most weight to treating sources, then to examining sources like CE sources, and the least weight to nonexamining sources, such as MCs and PCs. One commenter said without this hierarchy, our adjudicators would have a more difficult time evaluating evidence.

One organization that represents claimant representatives noted that if we do not keep the treating source rule, the treatment relationship should be a more important factor for consideration of medical opinions and prior administrative medical findings than the factors of supportability and consistency. Another commenter disagreed with our reasons for revising the factors for considering medical opinions and prior administrative medical findings.

[34] See 42 U.S.C. 902(a)(7) and current 404.1503(c) and 416.903(c).

[35] See current 20 404.1512(b)(vii), 404.1527(e)(1)(i) and (iii), 416.912(b)(vii), and 416.927(e)(1)(i) and (iii).

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The commenters who supported changing our rules agreed with our proposal to consider the supportability and consistency factors as the most important factors in assessing persuasiveness. These commenters said that this approach better reflects the actual state of health care today and allows adjudicators to focus more on the content of the evidence than on the source.

Response: While we understand the perspectives presented in these comments, we are not retaining the treating source rule in final 404.1520c and 416.920c for claims filed on or after March 27, 2017. Since we first adopted the current treating source rule in 1991, the healthcare delivery system has changed in significant ways that require us to revise our policies in order to reflect this reality. Many individuals receive health care from multiple medical sources, such as from coordinated and managed care organizations, instead of from one treating AMS.[36] These individuals less frequently develop a sustained relationship with one treating physician. Indeed, many of the medical sources from whom an individual may seek evaluation, examination, or treatment do not qualify to be ''treating sources'' as defined in current 404.1502 and 416.902 because they are not AMSs. These final rules recognize these fundamental changes in healthcare delivery and revise our rules accordingly.

Courts reviewing claims under our current rules have focused more on whether we sufficiently articulated the weight we gave treating source opinions, rather than on whether substantial evidence supports our final decision. As the Administrative Conference of the United States' (ACUS) Final Report explains, these courts, in reviewing final agency decisions, are reweighing evidence instead of applying the substantial evidence standard of review, which is intended to be highly deferential standard to us.[37]

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

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

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

Finally, our current rules do not create an automatic hierarchy for treating sources, examining sources, then nonexamining sources to which we must mechanically adhere. For example, adjudicators can currently find a treating source's medical opinion is not well-supported or is inconsistent with the other evidence and give it little weight, while also finding a medical opinion from an examining source, such as a consultative examiner, or nonexamining source, such a medical or psychological consultant, is supported and consistent and entitled to great weight. These final rules help eliminate confusion about a hierarchy of medical sources and instead focus adjudication more on the persuasiveness of the content of the evidence.

Comment: Instead of ending the treating source rule, some commenters asked us to reflect modern healthcare delivery by requiring our adjudicators to provide written analysis about how they consider medical opinions from any medical source from whom an individual chooses to receive evaluation, examination, or treatment, regardless of whether the medical source is an AMS.

Response: We carefully considered these comments, and we are adopting them. We agree that our rules need to reflect modern healthcare delivery, and that is a main reason we are ending the treating source rule. We further agree that our rules should reflect that individuals' own medical sources may not be AMSs. Therefore, these final rules state that we will consider and articulate our consideration of all medical opinions, regardless of AMS status, consistent with the standard we set forth for AMSs in proposed 404.1520c and 416.920c.

Under proposed sections 404.1520c(b)(4) and 416.920c(b)(4), we said that we would articulate how we consider the medical opinion(s) from a medical source who is not an AMS only if we found it to be well-supported and consistent with the record and more valuable and persuasive than the medical opinion(s) and prior administrative medical findings from all of the AMSs in the individual's case record. We are not adopting proposed 404.1520c(b)(4) and 416.920c(b)(4) in these final rules in order to ensure that our rules on articulation reflect the realities of the current healthcare delivery system.

Comment: A few commenters opposed our proposal to end the treating source rule because they said the proposed rules would create arbitrary and inconsistent decisionmaking.

Response: We disagree with these comments because these final rules require our adjudicators to consider all of the factors in final 404.1520c and 416.920c for all medical opinions and, at a minimum, to articulate how they considered the supportability and consistency factors for all of a medical source's medical opinions or prior administrative medical findings.

These final rules improve upon our current rules in several ways. For example, we will require our adjudicators to articulate how they consider medical opinions from all medical sources, regardless of AMS status, to reflect the changing nature of

[36] Kaiser Commission on Medicaid and the Uninsured, Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants, available at *http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8167.pdf;* Administrative Conference of the United States, SSA Disability Benefits Programs: Assessing the Efficacy of the Treating Physician Rule, pp. 25–37 (April 3, 2013), available at *http://www.acus.gov/sites/default/files/documents/Treating_Physician_Rule_Final_Report_4-3-2013_0.pdf.*

[37] 81 FR at 62572.

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healthcare delivery. Therefore, we expect these final rules will enhance the quality and consistency of our decisionmaking, and they will provide individuals with a better understanding of our determinations and decisions.

Comment: Some commenters suggested that instead of changing the treating source rule, we should provide our adjudicators with additional training about it, and increase our quality control measures, so that there are fewer appeals and remands about this issue.

Response: We agree with the comments to provide training and quality control measures to ensure policy compliance with our rules, but we are adopting our proposal to end the treating source rule for claims filed on or after March 27, 2017. The suggestion that we not end the treating source rule would neither align our policies with the current state of medical practice, nor would we expect it to result in substantially fewer appeals and remands about this issue.

To account for the changes in the way healthcare is currently delivered, we are adopting rules that focus more on the content of medical opinions and less on weighing treating relationships against each other. This approach is more consistent with current healthcare practice.

Additionally, we provide extensive training on our rules, and we will provide adjudicators with appropriate training on these final rules. In part because of our extensive training efforts, the work of our adjudicators is policy compliant and highly accurate. For example, in fiscal year 2015, the accuracy rate of our initial determinations was nearly 98 percent, and the overall rate at which the AC has agreed with hearing decisions has increased in recent years. We are committed to ensuring our disability adjudicators remain policy compliant; therefore, we will continue our existing ongoing efforts to train adjudicators on best practices for applying our policies, including the policies in these final rules.

Comment: A few commenters said that we should not adopt our proposed rules because the process of training our adjudicators and adapting our computer systems to comply with them will be difficult, time-consuming, and expensive.

Response: We are not adopting this comment. We believe that the changes we made to our rules will be beneficial to the administration of our programs because they will make our rules easier to understand and apply and will allow us to continue to make accurate and consistent decisions, while acknowledging the changing healthcare landscape. We agree that providing comprehensive training and updating our software to reflect the revisions in these final rules are critical, and we are confident that we will be able to provide the necessary training and software changes in a timely manner. Among our existing employees are dedicated teams that provide in-house training and software enhancements for all of our regulatory revisions. We are currently training our employees and are updating our systems to be ready for when these final rules become effective. We will also undertake quality control monitoring to ensure the training and software updates are effective and working as we intend.

Comment: One commenter requested that we clarify what ''consistency'' means when considering medical opinions and prior administrative findings. The commenter also recommended that we consider the consistency and treatment relationship with the claimant factors equally. The commenter explained, ''Given the brevity of some of these treatment relationships, medical sources may reasonably come to different conclusions about the claimant's impairments and functioning.''

Response: While we acknowledge that determining the consistency of medical opinions may be challenging in certain claims, we did not adopt this suggestion. Our adjudicators now use the consistency factor when they consider medical opinions and medical findings from MCs and PCs. Consistent with that approach, proposed and final 404.1520c and 416.920c explain that the more consistent a medical opinion or prior administrative medical finding is with the evidence from other medical sources and nonmedical sources in the claim, the more persuasive the medical opinion or prior administrative medical finding is.

Moreover, our use of the word ''consistent'' in the regulations is the same as the plain language and common definition of ''consistent.'' This includes consideration of factors such as whether the evidence conflicts with other evidence from other medical sources and whether it contains an internal conflict with evidence from the same medical source. We acknowledge that the symptom severity of some impairments may fluctuate over time, and we will consider the evidence in the claim that may reflect on this as part of the consistency factor as well. Thus, the appropriate level of articulation will necessarily depend on the unique circumstances of each claim.

The supportability and consistency factors provide a more balanced and objective framework for considering medical opinions than focusing upon the factors of consistency and the medical source's relationship with the individual. A medical opinion without supporting evidence, or one that is inconsistent with evidence from other sources, will not be persuasive regardless of who made the medical opinion.

Our final rules provide an appropriate framework to evaluate situations when multiple medical sources provide medical opinions that are not consistent. Our adjudicators will consider all of the factors when they determine how persuasive they find a medical opinion, and these factors are based on the current factors in our rules.

Comment: One commenter said the proposed rules did not contain sufficient guidance about when we would explain how we would consider opinions from sources who are not AMSs in claims with a filing date before the effective date of these final rules. The commenter expressed concern that more claims would be remanded if we did not include more policies from Social Security Ruling (SSR) 06–03p, which we are rescinding, into these final rules. A few other commenters asked us to retain the policies in SSR 06–03p about considering and providing written analysis about opinions from sources who are not AMSs for all claims.

Response: We agree with this comment, and we revised the final regulatory text about claims filed both before and after the effective date of these rules, March 27, 2017, to ensure we have provided clear and comprehensive guidance to our adjudicators and the public.

Under SSR 06–03p, we consider opinions from medical sources who are not AMSs and from nonmedical sources using the same factors we use to evaluate medical opinions from AMSs. We state that an adjudicator generally should explain the weight given to opinions from these sources, or otherwise ensure that the discussion of the evidence in the determination or decision allows an individual or subsequent reviewer to follow the adjudicator's reasoning, when such opinions may have an effect on the outcome of the case. In addition, when an adjudicator determines that an opinion from one of these sources is entitled to greater weight than a medical opinion from a treating source, the adjudicator must explain the reasons in the determination or decision if the determination is less than fully

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favorable under our current rules. In these final rules, we have included these policies from SSR 06–03p into final 404.1527 and 416.927 for claims filed before March 27, 2017.

In the NPRM,[38] we did not propose a rule that would have required our adjudicators to articulate how they considered evidence from nonmedical sources because these sections only discuss medical opinions, which come from medical sources. In response to the comment asking us to include guidance about how we will consider and provide articulation about how we considered evidence from nonmedical sources, we have made two changes. First, for claims filed before March 27, 2017, we have added a new paragraph, sections 404.1527(f) and 416.927(f), which explains how we will consider, and articulate our consideration of, opinions from medical sources who are not AMSs and from nonmedical sources. Second, we are also including regulatory text about evidence from nonmedical sources for claims filed on or after March 27, 2017. For these claims, new sections 404.1520c(d) and 416.920c(d) state that, ''We are not required to articulate how we considered evidence from nonmedical sources using the requirements in'' sections 404.1520c(a)–(c) and 416.920c(a)–(c) of the rules. This change clarifies our original intent.

Specifically, aside from where our regulations elsewhere may require an adjudicator to articulate how we consider evidence from nonmedical sources, such as when we evaluate symptoms,[39] there is no requirement for us to articulate how we considered evidence from nonmedical sources about an individual's functional limitations and abilities using the rules in final 404.1520c and 416.920c.

Comment: We received a comment from ACUS asking us to revise the preamble and our rules to reflect that the ACUS Assembly voted to adopt two of its principal recommendations from the ACUS Final Report[40] in the ACUS Conference Recommendations.[41] Another commenter asked us to disregard the ACUS Final Report and ACUS Conference Report because, he asserted, ACUS is unfamiliar with the realities that individuals face in daily life.

Response: We value the expertise ACUS provides to help improve Federal agencies' administrative processes, and specifically in this rulemaking process,[42] and we appreciate ACUS' continued interest in helping us improve the ways we administer our programs. At this time, we are adopting most of the ACUS Conference Recommendations that relate to the treating source rule in these final rules.

The first ACUS recommendation encourages us to use ''notice-and-comment rulemaking to eliminate the controlling weight aspect of the treating source rule in favor of a more flexible approach based on specific regulatory factors'' that are in our current rules. This recommendation also said that our adjudicators should articulate the bases for the weight given to medical opinions ''in all cases.''

We base the factors we will use to evaluate medical opinions in these final rules, which are based on notice-and-comment rulemaking, on the factors in our current rules. In response to ACUS's recommendation that our adjudicators should articulate the reasons for the weight given to medical opinions in all cases, we have revised final 404.1520c(b) and 416.920c(b) to state that we will articulate in our determination or decision how persuasive we find all of the medical opinions and all of the prior administrative medical findings in an individual's case record. We also provide specific articulation requirements for medical opinions from all medical sources, regardless of whether the medical source is an AMS.

The second ACUS recommendation asked us to both: (1) Recognize nurse practitioners (NP), physician assistants (PA), and licensed clinical social workers (LCSW) as AMSs consistent with their respective State law-based licensure and scope of practice, and (2) issue a policy statement that clarifies the value and weight to be afforded to opinions from NPs, PAs, and LCSWs.

As stated above, we are recognizing PAs and ARNPs, which includes NPs, as AMSs in these final rules. At this time, we are not recognizing LCSWs as AMSs, for the reasons we discussed previously.

With respect to ACUS's recommendation that we assign an inherent value to medical opinions from these medical sources, we will explain how we considered the medical opinions from these medical sources because we are not adopting our proposal to base the articulation requirements on whether the medical source is an AMS.

Comment: One commenter asked us to retain the treating source rule for child claims because pediatricians still have important treating relationships with child claimants. Another commenter asked us to give controlling weight to teacher assessments in child claims.

Response: While we are not adopting these comments, we agree that pediatricians have a valuable role in many child claims. Final sections 404.1520c(c) and 416.920c(c) explain that we will continue to consider the medical source's area of specialty and a medical source's relationship with an individual, including a child, as part of our evaluation of medical opinions. However, a treating pediatrician's relationship with a child patient is not sufficiently different from a treating doctor's relationship with an adult patient to warrant having a separate rule for evaluating medical opinions from treating pediatricians. Because we are moving away from applying the treating source rule for all medical sources, we are not expanding the treating source rule to give controlling weight to nonmedical sources like teachers.

Comment: One commenter suggested that instead of revising our rules about treating sources, we make additional efforts to develop evidence from treating sources, such as sending them functional questionnaires and asking them for medical opinions.

Response: We did not adopt this comment because our current practice is consistent with the Act's requirements that we make every reasonable effort to obtain evidence from all of an individual's medical sources.[43]

Comment: One commenter asked us to replace ''consider'' with ''evaluate'' and asserted that ''consider'' is a vague term.

Response: We did not adopt this comment because the use of the term ''consider'' is consistent with our current rules,[44] and it is easily distinguishable from the articulation requirements. Adoption of the term ''evaluate'' could imply a need to provide written analysis, which is not what we intend. Therefore, we have

[38] 81 FR at 62583–84 and 62592–93.

[39] See current 404.1529 and 416.929.

[40] Administrative Conference of the United States, SSA Disability Benefits Programs: Assessing the Efficacy of the Treating Physician Rule (April 3, 2013), available at *http://www.acus.gov/sites/default/files/documents/Treating_Physician_Rule_Final_Report_4-3-2013_0.pdf.*

[41] Conference Recommendation 2013–1, Improving Consistency in Social Security Disability Adjudications. 78 FR 41352 (July 10, 2013), also available at *https://acus.gov/recommendation/improving-consistency-social-security-disability-adjudications.*

[42] ACUS is ''an independent federal agency dedicated to improving the administrative process through consensus-driven applied research, providing nonpartisan expert advice and recommendations for improvement of federal agency procedures.'' About the Administrative Conference of the United States (ACUS), available at *http://www.acus.gov/about-administrative-conference-united-states-acus.*

[43] 42 U.S.C. 423(d)(5)(B) and 1382c(a)(1)(H)(i).

[44] See, for example, 404.1520b and 416.920b.

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continued to use the term ''consider'' in these final rules.

Comment: One commenter offered an alternative approach to ending the treating source rule. The alternative approach would continue to give controlling weight to treating physician opinions in most circumstances, significantly limit how persuasive we could find a CE source's opinions, and limit the role of MCs and PCs to identifying when additional medical evidence is needed to adjudicate a claim.

Response: We are not adopting this suggestion because it is not consistent with section 221(h) of the Act, as amended by BBA section 832. As we noted earlier in the preamble, under section 221(h) of the Act, we are now required to make ''every reasonable effort'' to ensure that a qualified physician (in cases involving a physical impairment) or a qualified psychiatrist or psychologist (in cases involving a mental impairment) has completed the medical review of the case and any applicable residual functional capacity (RFC) assessment, not just identify when additional medical evidence is needed to adjudicate a claim.

Furthermore, the suggestion would not bring our rules into alignment with the modern healthcare delivery. Our rules focus on the content of the medical opinions in evidence, rather than on the source of the evidence. The commenter's proposal would require us to adopt the opinions of either a treating physician or a consultative examiner to determine if the claimant meets our statutory definition of disability. This would confer upon these other sources the authority to make the determination or decision that we are required to make, and would be an abdication of our statutory responsibility to determine whether the person meets the statutory definition of disability.

Comment: A few commenters said we should never consider evidence from our MCs and PCs to be more persuasive than evidence from an individual's own medical source because MCs and PCs are unqualified and misrepresent the evidence they review.

Response: We did not adopt this comment because we maintain strict requirements for who may serve as a qualified MC or PC.[45] MCs and PCs have valuable experience in our adjudicative processes, and their review of all of the evidence we receive provides them with a comprehensive perspective that other medical sources, including an individual's own medical sources, may not have.

Comment: One commenter said we provided no evidence to support the NPRM's statement that individuals less frequently develop a sustained relationship with one treating physician now than when they did when we published the treating source rule in 1991.

Response: In the preamble to the NPRM, we provided a list of sources of evidence in footnote 119, which refers readers to the ACUS Final Report.[46] Examples of sources that ACUS cites in section III.A. of its Final Report include:

- Sharyn J. Potter & John B. McKinlay, *From a Relationship to Encounter: An Examination of Longitudinal and Lateral Dimensions in the Doctor-Patient Relationship,* 61 SOC. SCI. & MED. 465, 466–470 (2005). These authors described the ''longitudinal changes to doctor-patient relationship in latter decades of 20th century as corporatist model of health care took hold, due largely to 'exponential growth of managed health care in the 1980s and 1990s [that] drastically changed the roles of both physicians and patients.' '' [47]
- John W. Saultz & Waleed Albedaiwi, *Interpersonal Continuity of Care and Patient Satisfaction: A Critical Review,* 2 ANNALS OF FAM. MED. 445, 445 (Sept./Oct. 2004). This article reports that, '''Changes in the American healthcare system during the past decade have made it increasingly difficult to establish such long-term trusting relationships between physicians and patients. Some authors have questioned whether a personal model of care is feasible, as health plans increasingly have required provider changes for economic reasons.' '' [48]
- Paul Nutting et al., *Continuity of Primary Care: To Whom Does it Matter and When?,* 1 ANNALS OF FAM. MED. 149, 154 (Nov. 2003) This article states, '' 'The current organizational and financial restructuring of the health care system creates strong pressures against continuity with employers changing plans, and plans changing providers. Forced disruption in continuity of care is common, particularly for those with a managed care type of insurance.' '' [49]

There are other similar sources of evidence establishing that individuals less frequently develop a sustained relationship with one treating physician now on pages 25–28 of the ACUS Final Report, including in the footnotes.

Comment: Some commenters opined that increasing complexity in cases and voluminous files provide insufficient reasons for moving away from the treating source rule.

Response: The increasing complexity in cases and voluminous files were not reasons that we provided in support of moving away from the treating source rule. We are moving away from the treating source rule to align our policies more closely with the ways that people receive healthcare today.

Instead, the increasing complexity of cases and voluminous files were reasons we provided in support of our proposed rules about how we would articulate our consideration of medical opinions. As explained elsewhere in this preamble, we received comments raising concern with certain aspects of the proposed articulation requirements. As a result, we revised the final rules in several ways, such as to require adjudicators to articulate how they considered medical opinions from all medical sources, rather than only from AMSs, in final 404.1520c and 416.920c.

As we explained in the preamble to the NPRM,[50] it is not administratively feasible for us to articulate how we considered all of the factors for all of the medical opinions and prior administrative medical findings in all claims. As we noted earlier in the preamble, our goal in these final rules is to continue to ensure that our adjudicative process is both fair and efficient. We have an obligation to treat each claimant as an individual and to decide his or her claim fairly. We also have an obligation to all individuals to provide them with timely, accurate determinations and decisions.

Our experience since 1991 using the treating source rule shows that the articulation requirement in the current rule, which requires adjudicators to address each opinion, rather than addressing the opinions on a source-level, does not always foster those two goals. Accordingly, we believe it is appropriate to revise the articulation requirement in our current rules. We believe that the changes we have made from the NPRM address the concerns raised by the commenters, while still allowing us to ensure that our administrative process is both fair and efficient.

[45] See current 404.1616 and 416.1016, as revised by final 404.1616 and 416.1016 to accommodate section 221(h) of the Act, as amended by BBA section 832.

[46] Administrative Conference of the United States, SSA Disability Benefits Programs: Assessing the Efficacy of the Treating Physician Rule (April 3, 2013), available at *http://www.acus.gov/sites/default/files/documents/Treating_Physician_Rule_Final_Report_4-3-2013_0.pdf.*

[47] *Id.* at 26, footnote 205.

[48] *Id.* at 26, footnote 206.

[49] *Id.* at 28, footnote 220.

[50] 81 FR at 62574.

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Comment: A few commenters disagreed with how we characterized some of the legal precedents we cited as in the preamble to the NPRM, such as *Black & Decker Disability Plan* v. *Nord.*[51] These commenters asserted that *Black & Decker* reflected positively on the 1991 treating source rule regulations, and that many courts support the treating source rule's deferential standard.

Response: We included *Black & Decker* in the preamble to the NPRM[52] because the opinion notes that, ''the assumption that the opinions of a treating physician warrant greater credit than the opinions of plan consultants may make scant sense when, for example, the relationship between the claimant and the treating physician has been of short duration, or when a specialist engaged by the plan has expertise the treating physician lacks. And if a consultant engaged by a plan may have an 'incentive' to make a finding of 'not disabled,' so a treating physician, in a close case, may favor a finding of 'disabled.' ''[53]

Although the *Black & Decker* court was referring to medical consultants contracted under ERISA plans, the concerns about short treatment relationships and lack of specialization are equally applicable in the context of disability adjudication under our rules. Notably, ACUS agrees with our interpretation of the discussions in these opinions.[54] Additionally, setting aside the Court's decision in Black and Decker, the other rationale we provided in the NPRM for revising our policy on how we consider treating source and other medical source opinions remains compelling.

Comment: Some commenters, including the authors of a law review article mentioned in section VI.D.5. of the NPRM preamble,[55] submitted comments stating we had inaccurately presented parts of the content of that article and their position on the treating physician rule.

Response: We appreciate the commenters' concerns and their interest in our programs and this rulemaking proceeding. We regret the mischaracterization of the authors' position in their article. We note that the other rationale discussed in the NPRM and these final rules remains compelling.

[51] 538 U.S. 822 (2003).

[52] 81 FR 62572.

[53] 538 U.S. at 832.

[54] See ACUS Final Report at 43.

[55] Richard E. Levy & Robert L. Glicksman, Agency-Specific Precedents, 89 TEX. L. REV. 499, 546 (2011).

Articulation Requirements

Comment: A few commenters expressed concern with the factors that we proposed to consider when evaluating medical opinions and prior administrative medical findings. One commenter indicated that we should not elevate consistency above the other factors. Another commenter thought that the consistency factor would automatically make a longitudinal record subject to being found inconsistent. Other commenters said we should continue to use our existing factors, or first consider the factor of a longstanding treatment relationship, to evaluate the persuasiveness of medical opinions and prior administrative medical findings. Some commenters were concerned with our proposal to add ''understanding our policy'' and ''familiarity with the record'' to our list of factors because they may appear to favor evidence from our MCs and PCs over an individual's own medical sources.

Response: We agree, in part, with these comments. We are adopting our proposal to consider supportability and consistency as the two most important factors when we evaluate the persuasiveness of medical opinions and prior administrative medical findings. Our experience adjudicating claims demonstrates that these factors are more objective measures than the relationship with the claimant factor and are the same factors we look to as part of the current treating source rule. While we agree that there is no hierarchy to the remaining factors, we did not revise our rules to include this language in the regulatory text. Instead, we agree with the comments that we should revise the regulatory text to eliminate any appearance that inherently we favor evidence from MCs or PCs over evidence from an individual's own medical sources, and vice versa. Therefore, we made several revisions to the regulatory text in final 404.1520c and 416.920c.

We revised the issues within the ''relationship with the claimant'' factor to read: length of the treatment relationship, examining relationship, frequency of examinations, purpose of the treatment relationship, and extent of the treatment relationship. This underscores our recognition that an individual's own medical source may have a unique perspective of an individual's impairments based on the issues listed, such as a long treatment relationship. We will consider the unique evidence in each claim that tend to support or weaken how persuasive we find these issues.

Similarly, under both our current rules and the proposed rules, we may consider a medical source's familiarity with the entire record and his or her understanding of our policy. In our proposed rules, we proposed to separately list ''understanding our policy'' and ''familiarity with the record'' as individual factors instead of examples of ''other factors'' as in the current rules. Some commenters were concerned that this change favored our MCs and PCs, who often review all evidence in a claim and are trained in our policies. This was not our intent, and we proposed to reorganize the factors to clarify, not change, our policy on this point. Therefore, we agree with the comments that it would be best to list these issues within ''other factors.''

We also recognize that new evidence submitted after an MC or PC provided a prior administrative medical finding may affect how persuasive that finding is at subsequent levels of adjudication. We are adding in final 404.1520c(c)(5) and 416.920c(c)(5) that when we consider a medical source's familiarity with the other evidence in a claim, we will also consider whether new evidence we receive after the medical source made his or her medical opinion or prior administrative medical finding makes the medical opinion or prior administrative medical finding more or less persuasive.

Additionally, we recognize that evidence from a medical source who has a longstanding treatment relationship with an individual may contain some inconsistencies over time due to fluctuations in the severity of an individual's impairments. Our adjudicators will consider this possibility as part of evaluation of the consistency factor, as they do so under our current rules. We will also include this issue within our training to our adjudicators.

Comment: Some commenters were concerned that, by moving away from assigning a specific weight to opinions and prior administrative medical findings, we would add subjectivity into the decisionmaking process and said we would only require our adjudicators to think about the evidence but not provide written analysis. Other commenters suggested that by requiring articulation on only two factors—supportability and consistency—our decisions would not sufficiently inform the individual or a reviewing Federal court of the decisionmaker's reasoning, which would lead to more appeals to and remands from the courts.

Response: While we understand the concerns in these comments, we are adopting our proposal to look to the

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persuasiveness of medical opinions and prior administrative medical findings for claims filed on or after March 27, 2017. Our current regulations do not specify which weight, other than controlling weight in a specific situation, we should assign to medical opinions. As a result, our adjudicators have used a wide variety of terms, such as significant, great, more, little, and less. The current rules have led to adjudicative challenges and varying court interpretations, including a doctrine by some courts that supplants the judgment of our decisionmakers and credits as true a medical opinion in some cases.

By moving away from assigning a specific weight to medical opinions, we are clarifying both how we use the terms ''weigh'' and ''weight'' in final 404.1520c(a), 404.1527, 416.920c(a), and 416.927 and also clarifying that adjudicators should focus on how persuasive they find medical opinions and prior administrative medical findings in final 404.1520c and 416.920c. Our intent in these rules is to make it clear that it is never appropriate under our rules to ''credit-as-true'' any medical opinion.

We are also stating in final 404.1520c(b) and 416.920c(b) what minimum level of articulation we will provide in our determinations and decisions to provide sufficient rationale for a reviewing adjudicator or court. In light of the level of articulation we expect from our adjudicators, we do not believe that these final rules will result in an increase in appeals or remands from the courts.

Comment: We received various comments regarding our proposal in sections 404.1520c(b) and 416.920c(b) about when we would articulate how we considered medical opinions from medical sources who are not AMSs. A few commenters supported our proposal. However, several other commenters, including Members of Congress, expressed concern with the proposed changes. Some commenters said the changes would result in less transparency because adjudicators would have ''too much individual discretion to dismiss key evidence without providing a rationale.'' Other commenters said that our proposed rules would not allow reviewing courts to determine whether substantial evidence supports our decisions.

Response: We partially adopted these comments, and we appreciate the perspective of the commenters who expressed concern with the proposed rules. We are committed to having a transparent, fair, and balanced adjudicative process that ensures that every entitled individual receives the disability benefits or payments and that every individual understands why he or she is not entitled to benefits. We agree with the majority of commenters that we should articulate how we consider medical opinions from any of an individual's own medical sources, regardless of whether that source is an AMS.

Therefore, we revised final 404.1520c(c) and 416.920c(c) to require our adjudicators to articulate how they consider medical opinions from all medical sources, regardless of AMS status. This revision helps align our rules with current medical practice and recognizes that individuals may obtain evaluation, examination, or treatment from medical sources who are not AMSs.

To account for this change, we are not adopting proposed 404.1520c(b)(4) and 416.920c(b)(4) in these final rules, which would have stated standards about when we would articulate how we considered medical opinions from medical sources who are not AMSs. We also revised final 404.1520c(a)–(b) and 416.920c(a)–(b) to clarify that there is a difference between considering evidence and articulating how we consider evidence. We consider all evidence we receive, but we have a reasonable articulation standard for determinations and decisions that does not require written analysis about how we considered each piece of evidence.

We expect that the articulation requirements in these final rules will allow a subsequent reviewer or a reviewing court to trace the path of an adjudicator's reasoning, and will not impede a reviewer's ability to review a determination or decision, or a court's ability to review our final decision.

Comment: One commenter asked for clarification about what we meant by ''medical source'' in proposed 404.1520c(b)(1) and 416.920c(b)(1), particularly when an entity provides us with evidence. The commenter asked if we were referring to the same health care provider, the same clinic, the same medical group, or the same hospital.

Response: Under both our current and these final rules, only an individual, not an entity, can be a medical source. When an entity provides us with evidence from multiple medical sources, we will evaluate each medical source's evidence separately instead of considering the evidence as coming from one source.

Comment: One commenter agreed with our proposal to require an adjudicator to discuss other relevant factors when we find two medical sources' medical opinion(s) or prior administrative medical finding(s) equally persuasive. Another comment asserted that the NPRM did not provide much guidance as to when medical opinions are both equally well-supported and consistent with the record.

Response: We agree with the first commenter that this requirement provides an appropriate standard about when an adjudicator has discretion to discuss the other relevant factors. Because the content of evidence, including medical opinions and prior administrative medical findings, varies with each unique claim, it would not be appropriate to set out a detailed rule for when this situation may occur. We expect that each adjudicator will use his or her discretion to determine when this situation occurs.

The final rules include sufficient guidance to adjudicators in determining when this situation exists. Under final sections 404.1520c(b)(3) and 416.920c(b)(3), the medical opinions or prior administrative medical findings must be ''both equally well-supported'' under sections 404.1520c(c)(1) or 416.920c(c)(1) ''and consistent with the record'' under sections 404.1520c(c)(2) or 416.920c(c)(2). In addition, the opinions or prior administrative medical findings must not be ''exactly the same.'' Under these circumstances, we will articulate how we considered the other most persuasive factors in sections 404.1520c(c)(3)–(c)(5) or 416.920c(c)(3)–(c)(5) for those medical opinions or prior administrative medical findings in the determination or decision.

Comment: One commenter thought we would no longer provide rationale about why we did not adopt a medical opinion from an individual's doctor. A few commenters believed that the proposed rule would reduce our articulation burden and would increase inconsistency in how we evaluate individuals.

Response: While we understand some commenters were concerned about these issues, these final rules continue the requirement in current 404.1527 and 416.927 to articulate how we consider medical opinions from an individual's own doctor. In fact, these final rules enhance the current requirements in several ways, such as requiring articulation about medical opinions from all of an individual's medical sources, making consistency and supportability the most important factors, and clarification of the factors themselves. These improvements will increase the consistency in how we evaluate claims, and we also expect them to reduce remands.

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Comment: One commenter asked us to adopt the medical opinions of highly-specialized doctors without considering the other factors.

Response: After careful consideration, we are not adopting this comment. The specialization of the medical source who provides a medical opinion or prior administrative medical finding is one of the factors we consider when we evaluate how persuasive a medical opinion or prior administrative medical finding is. Under our current rules in 404.1527(c) and 416.927(c), we consider several factors when we decide what ''weight'' to give to a medical opinion, and we do not consider the specialization of the medical source in isolation. Evaluating the persuasiveness of a medical opinion requires consideration of several factors and in context of all of the evidence in the claim.

Comment: One commenter asked us to add a factor for considering medical opinions that would inquire about whether the individual is indigent, because such individuals cannot afford psychotherapy.

Response: We are not adopting this comment because the factors for considering medical opinions and prior administrative medical findings relate to the persuasiveness of the evidence presented, not to the financial status of the individual. We will consider and explain how we considered medical opinions of an individual's medical sources regardless of whether the medical evaluation, examination, or treatment occurred in a free or low cost health clinic for indigent individuals.

Comment: One commenter asked whether we intended to make two separate findings about the value and persuasiveness of medical opinions, or whether we intended to require one finding. The commenter opposed requiring two separate findings for each medical opinion because that would increase the articulation burden on our adjudicators.

Response: We appreciate the question and the opportunity to clarify that we are not requiring two separate findings. Our adjudicators need only explain how persuasive they found a medical opinion or prior administrative medical finding in their determinations or decisions. As we state in final 404.1520c(b) and 416.920c(b), ''[w]e will articulate in our determination or decision how persuasive we find all of the medical opinions and all of the prior administrative medical findings in your case record.'' There is no requirement that our adjudicators provide a second analysis about how valuable a medical opinion or prior administrative medical finding is.

Comment: A few commenters said that our proposed rules about how we would articulate how we considered medical opinions, and that we would not articulate our consideration of disability examiner findings, statements on issues to the Commissioner, and decisions by other governmental agencies and nongovernmental entities, violated due process and 42 U.S.C. 405(b), which requires us to include in a determination or decision that is not fully favorable to an individual, a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the reason(s) upon which we based the determination or decision. Some of these commenters said reviewing courts would increase the number of remands because they would be unable to review our adjudicators' rationale.

Response: Our current rules, the proposed rules, and these final rules are consistent with and further the goals of 42 U.S.C. 405(b) and the principles of due process. The statute does not require us to explain how we consider every piece of evidence we receive. Instead, section 405(b) requires us to include in a determination that is not fully favorable to an individual, a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the reason(s) upon which we based the determination or decision. The intent of the statute was not to impose a burdensome articulation requirement.[56] Rather, the intent was to remedy a prior concern that individuals were receiving notices that their claims for disability benefits had been denied without any personalized articulation of the evidence.[57]

We will articulate how we considered the medical opinions from all medical sources and prior administrative medical findings in a claim. This articulation will include the supportability and consistency factors, which generally includes an assessment of the supporting objective medical evidence and other medical evidence, and how consistent the medical opinion or prior administrative medical findings is with other evidence in the claim. Therefore, the final rules are consistent with the intent of the statute that we provide a statement of the case, setting forth a discussion of the evidence, and stating the reasons upon which we based the determination.

As to the comments that these rules do not provide due process, these final rules do not violate the Due Process Clause of the Fifth Amendment to the Constitution. The final rules do not categorize individuals based on their characteristics or deprive an individual of a protected property interest. The rules also ensure that our procedures are fair and provide individuals with appropriate procedural protections. Nothing in constitutional principles of equal protection is inconsistent with these final rules.

Comment: We received a few comments raising concern about the interactions between the proposed rules and some Federal statutes, and the interactions between the proposed rules and judicial review. A few commenters said our proposed rules were in conflict with 42 U.S.C. 405(g). One commenter said our proposed rules were in conflict with 42 U.S.C. 404(a). One commenter said our proposed rules violated the Ninth Circuit's ''credit-as-true doctrine.'' Another commenter said the treating source rule provides for uniformity between Federal courts and us and minimizes delays to claimants by limiting unnecessary court reviews. A few commenters said courts would continue to defer to evidence from a claimant's own medical sources regardless of the content of our rules.

Response: We do not agree with these comments. 42 U.S.C. 404(a) and 405(g) do not directly apply to the proposed or final regulatory sections. 42 U.S.C. 404(a) addresses how we assess underpayments and overpayments, and nothing in these final rules address these issues. Similarly, 42 U.S.C. 405(g) addresses procedures for individuals to appeal their decisions to Federal court, and these final rules do not affect these rights.

Federal courts are bound to uphold our decisions when they are supported by substantial evidence and when we have applied the appropriate legal standards in our decisions. While a court has the authority to review the validity of our regulations, the fact that some courts previously have adopted a credit as true rule does not mean that we are required to adopt such a rule in

[56] *See* section 305 of the Social Security Disability Amendments of 1980, Public Law 96–265, 94 Stat. 441, 457. In amending section 405(b), Congress intended for the required personalized denial notice to be ''brief, informal, and not technical,'' H.R. Conf. Rep. 96–944, at 58 (1980), and did not intend for it to be a voluminous document, S. Rep. 96–408 at 57 (1979).

[57] *See* H.R. Conf. Rep. 96–944, at 58 (1980) (noting that under the law at the time, ''[t]here is no statutory provision setting a specific amount of information to explain the decision made on a claim for benefits.''); S. Rep. 96–408 at 56 (1979) (noting that under the law at the time, ''[n]otices to claimants regarding the Secretary's decision on their claim for disability benefits provides little guidance as to the causes for a denial.'')

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our regulations.[58] Those courts that have adopted the credit as true rule have not done so based on any specific requirement of the Act, and the statute does not mandate that we apply such a rule.

In our view, the credit as true rule supplants the legitimate decisionmaking authority of our adjudicators, who make determinations or decisions based on authority delegated by the Commissioner. The credit as true rule is neither required by the Act nor by principles of due process. It is also inconsistent with the general rule that, when a court finds an error in an administrative agency's decision, the proper course of action in all but rare instances is to remand the case to the agency for further proceedings. Accordingly, we decline to adopt the credit as true rule here.

We expect that courts will defer to these regulations, which we adopted through notice and comment rulemaking procedures pursuant to the Commissioner's exceptionally broad rulemaking authority under the Act. The rules are essential for our administration of a massive and complex nationwide disability program where the need for efficiency is self-evident. The rules are neither arbitrary nor capricious, nor do they exceed the bounds of reasonableness. Under these circumstances, we are confident that our rules are valid.[59]

Comment: A few commenters asked us to require MCs and PCs to identify what medical evidence they reviewed and disclose the amount of time spent reviewing each claimant's file to enable later decisionmakers to assess the supportability and consistency factors more effectively. These commenters also asked us to instruct our adjudicators to consider the completeness of the record at the time of review and the time spent reviewing the record when evaluating prior administrative medical findings.

Response: While we agree that the specific evidence an MC or PC reviewed is probative, we did not accept this comment because MCs and PCs are required to evaluate all of the evidence in the claim file at the time they make their medical findings under our rules. Consistent with 42 U.S.C. 405(b), our current rules also require that when we make an initial determination, our written notice will explain in simple and clear language what we have determined and the reasons for and the effect of our determination. When we make a determination of disability that is in whole or in part unfavorable to an individual, our rules also require our written notice to ''contain in understandable language a statement of the case setting forth the evidence on which our determination is based.'' [60] Adjudicators at subsequent levels of appeal can also determine what evidence already existed in the claim file when the MC or PC made his or her medical findings by reviewing data in the claims folder.

We also did not adopt the suggestion to measure and document MC and PC review time to help subsequent adjudicators consider supportability and consistency of their adjudicative findings because review time does not provide information about supporting evidence or consistency of the evidence.

Sections 404.1521 and 416.921—Establishing That You Have a Medically Determinable Impairment

Comment: One commenter asked us to align our requirements for establishing an impairment with the International Classification of Functioning (ICF) used by the World Health Organization.[61] The ICF is a framework for describing and organizing information on functioning and disability. The commenter suggested that if we were to align our requirements for establishing an impairment with the ICF, medical sources who provide evidence to us could use a standardized language and conceptual basis for the definition and measurement of health and disability.

Response: While we are always looking for ways to improve how we adjudicate disability claims, we are not adopting the comment at this time. It is unclear how the ICF would be helpful in our adjudication of disability claims because the ICF's definition of disability differs from the requirements in the Act. The Act defines disability as ''the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment, which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.'' [62]

In contrast, the ICF views ''disability and functioning as outcomes of interactions between *health conditions* (diseases, disorders and injuries) and *contextual factors.*'' [63] Included in these contextual factors ''are external *environmental factors* (for example, social attitudes, architectural characteristics, legal and social structures, as well as climate, terrain, and so forth); and internal *personal factors,* which include gender, age, coping styles, social background, education, profession, past and current experience, overall behaviour pattern, character and other factors that influence how disability is experienced by the individual.'' [64] Therefore, an individual could have a ''disability'' as contemplated by the ICF without meeting the Act's definition of disability.

Sections 404.1522 and 416.922—What We Mean by an Impairment(s) That Is Not Severe

Comment: One commenter stated that, ''controlling law on the statutory interpretation of 'severe' is that it should have the 'minimalist effect' on the activities of daily living.''

Response: We did not adopt this comment because we proposed to move the current definition from current 404.1521(a) and 416.921(a) into proposed 404.1522(a) and 416.922(a) as part of the effort to reorganize our regulations for ease of use, not to change the current definition. The definition of ''non-severe'' impairment in our regulations has been the same since 1985,[65] and it has been substantially the same since we first defined the term in 1980.[66] The U.S. Supreme Court upheld the regulatory definition in *Bowen* v. *Yuckert.*[67]

Sections 404.1523 and 416.923—Multiple Impairments

Comment: One commenter opposed proposed 404.1523 and 416.923, which explains how we consider an individual's multiple impairments, because he said we would not consider all impairments in combination.

Response: We decided to adopt these proposed revisions as part of our effort to make our rules easier to understand and use. These sections combine content from current 404.1522, 404.1523, 416.922, and 416.923 without any substantive change in language. These current sections discuss related issues- our policies for considering claims involving multiple impairments.

[58] See *National Cable and Telecommunications Ass'n v. Brand X Internet Services*, 545 U.S. 967, 982 (2005).

[59] See 5 U.S.C. 553 and E.O. 12866, as supplemented by E.O. 13563.

[60] Current 404.904 and 416.1404.

[61] *See* World Health Organization, International Classification of Functioning, Disability and Health (ICF), *http://www.who.int/classifications/icf/en/.*

[62] 42 U.S.C. 423(d)(1)(A) and 1382c(a)(3)(A).

[63] World Health Organization, Towards a Common Language for Functioning, Disability and Health—ICF, p. 10, 2002.

[64] *Id.*

[65] See 50 FR 8726, 8728 (March 5, 1985).

[66] See 45 FR 55566, 55588 (August 20, 1980).

[67] 482 U.S. 137 (1987).

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Under the final rules, as under the current rules, we will consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity when we determine whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility. If we do find a medically severe combination of impairments, we will consider the combined impact of the impairments throughout the disability determination process. Since our final rules require us to consider the combined effect of an individual's impairments, we are adopting the text as proposed in final 404.1523 and 416.923.

Sections 404.1527 and 416.927—Evaluating Opinion Evidence for Claims Filed Before March 27, 2017

Comment: One commenter suggested that the phrase ''typical for your condition(s),'' as part of the definition of ''treating source'' in proposed 404.1527 and 416.927, which will be applied to claims filed before March 27, 2017, should include the population of indigent individuals who cannot afford psychotherapy as frequently as those who can afford to pay for more frequent sessions.

Response: We are not adopting this comment. The definition of ''treating source'' in proposed 404.1527 and 416.927, including the words ''typical for your condition(s),'' comes from our current definition of treating source in current 404.1502 and 416.902. We will continue to apply our current rules for evaluating evidence from a treating source, including this definition, to claims filed before March 27, 2017. We moved this definition to proposed 404.1527 and 416.927 to locate together more of the rules that we will use for claims filed before March 27, 2017.

For claims filed on or after March 27, 2017, the rules for considering medical opinions will not use the term ''treating source'' or the phrase ''typical for your condition(s).''

Sections 404.1616 and 416.1016—Medical Consultants and Psychological Consultants

Comment: Several commenters opposed our proposal to recognize master's level psychologists licensed for independent practice as psychological consultants (PC) in proposed 404.1616 and 416.1016. These commenters said we should continue to follow our current rules in 404.1616(e) and 416.1016(e) because they recognize the most qualified licensed psychologists, who are doctorate-level clinical psychologists, to be PCs. These commenters said we should maintain a higher level of qualifications for a psychologist to be a PC than we require a psychologist to be an acceptable medical source (AMS).

Response: We agree with these commenters and are not adopting our proposal to revise the qualifications to be a PC in these final rules. Instead, we will continue to follow our current requirements about who can be a PC in final 404.1616 and 416.1016.

Our rules only authorize us to recognize a psychologist to be a PC if he or she: (1) Is licensed or certified as a psychologist at the independent practice level of psychology by the State in which he or she practices; and (2)(i) Possesses a doctorate degree in psychology from a program in clinical psychology of an educational institution accredited by an organization recognized by the Council on Post-Secondary Accreditation; or (ii) Is listed in a national register of health service providers in psychology which we deem appropriate; and (3) Possesses 2 years of supervised clinical experience as a psychologist in health service, at least 1 year of which is post-masters degree.

Comment: One commenter said our proposed use of the term ''every reasonable effort,'' relating to a medical consultant (MC) or PC completing the medical portion of the case review and any applicable RFC assessment, in proposed 404.1616, 404.1617, 416.1016, and 416.1017, was too broad.

Response: We did not adopt this comment because the term ''every reasonable effort'' as used in the NPRM and in the final rules is not new. In fact, it has appeared in section 221(h) of the Act since 1984, and Congress retained the phrase when it amended section 221(h) through the Bipartisan Budget Act of 2015 (BBA) section 832 in 2015. We have adopted the proposed procedural rules we will use to make ''every reasonable effort'' to have qualified physicians, psychologists, and psychiatrists review claims to final rules 404.1617 and 416.1017.

Comment: Some commenters opposed our proposal to limit MCs to only licensed physicians. The commenters stated that speech-language pathologists were uniquely qualified to assess the level of functional impairment and ability related to communication disorders. One of these commenters asked us to require that speech-language pathologists review all claims related to communication disorders at the initial and reconsideration levels as medical advisors.

Response: We agree that speech-language pathologists are highly qualified to assess level of functional impairment and ability related to communication disorders; therefore, we have retained them as AMSs. However, section 221(h) of the Act, as amended by BBA section 832, states that we must make every reasonable effort to ensure that a qualified physician (in cases involving a physical impairment) or a qualified psychologist or psychiatrist (in cases involving a mental impairment) completes the medical portion of the case review. A speech-language pathologist is not a ''qualified physician'' and therefore section 221(h) of the Act does not authorize us to recognize them as MCs or PCs.

To help retain the expertise of non-physician AMSs like speech-language pathologists, we created the role of a medical advisor in our subregulatory instructions.[68] These medical sources can review the evidence in the claim and provide case analysis that the adjudicative team will consider as evidence from a medical source in accordance with final 404.1513(a), 404.1520b, 404.1520c, 404.1527, 416.913(a), 416.920b, 416.920c, and 416.927, as appropriate. However, we are not adopting the suggestion to require Speech-Language Pathologist medical advisor input in every claim involving communication disorders at this time. The adjudicative team will use its professional judgment to determine whether to consult with a medical advisor(s) and how to consider medical advisor input on any case.

Comment: One commenter asked us to revise our rules to state that an MC who is a pediatrician must evaluate any child claim involving a physical impairment and cited section 1614(a)(3)(I) of the Act, which mandates that we make reasonable efforts to have a qualified pediatrician or other appropriate specialist evaluate a child's case. Another commenter asked us to allow licensed physicians such as development/behavioral pediatricians, child neurologists, and some primary care providers to act as PCs in a child claim involving a mental impairment because there is a shortage of child psychologists and psychiatrists. Another commenter opposed our rules that authorize psychiatrists to review physical impairments.

Response: While we appreciate the commenters' concerns, we did not adopt

[68] See POMS DI 24501.001 The Disability Determination Services (DDS) Disability Examiner (DE), Medical Consultant (MC), and Psychological Consultant (PC) Team, and the Role of the Medical Advisor (MA), available at *https://secure.ssa.gov/apps10/poms.nsf/lnx/0424501001.*

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them because our current rules are already sufficient and consistent with the Act. Consistent with the Act's requirements in section 1614(a)(3)(I), our current rules already state that we will make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the child's impairment(s) evaluates the case of the child.[69] The Act does not require us to have only a pediatrician be an MC in child claims involving a physical impairment(s).

Section 221(h) of the Act, as amended by BBA section 832, states that when there is evidence indicating the existence of a mental impairment in a claim, we may not make an initial determination until we have made every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity (RFC) assessment. If we make every reasonable effort to obtain the services of a licensed psychiatrist or qualified psychologist to review a claim involving a mental impairment, but the professional services are not obtained, a physician who is not a psychiatrist will review the mental impairment claim.[70]

Historically, we have not regulated which specialty of MC or PC must review cases involving specific impairments because each Disability Determination Service (DDS) has unique staffing considerations. Due to the continually changing nature of the medical profession, any future guidance we may issue about which medical specialties may review claims involving specific impairments would be best placed in our subregulatory instructions.

Comment: A few commenters wanted us to recognize optometrists and podiatrists as MCs. They said that BBA section 832's requirement that a licensed physician review claims involving physical impairments still authorized us to have optometrists and podiatrists as MCs.

Response: We recognize the specialized expertise that these medical sources can bring to claims, which is why we authorized them to be MCs prior to BBA section 832's effective date. However, neither optometrists nor podiatrists are qualified physicians, as is required by section 221(h) of the Act, as amended by BBA section 832. To retain access to their expertise, we created the medical advisor role in our subregulatory instructions so that DDSs may continue to request their expert analysis on claims.

Other Comments

Comment: Several commenters opposed the proposed policy changes in the NPRM that were inconsistent with the following Social Security Rulings (SSR): 96–2p, 96–5p, and 96–6p. Therefore, those commenters opposed rescinding the same SSRs.

Response: We explained in detail above and (as appropriate) in the preamble to our proposed rules, our reasons for adopting the policies in these final rules. Because the policies we are adopting in these final rules are inconsistent with those SSRs, we are rescinding them.

Comment: Some commenters disagreed with our proposed implementation process. These commenters said it would be difficult for adjudicators to follow different rules based on the filing date of the claim. One commenter said all claims should follow the new policies on the effective date, or in the alternative, fewer of the current policies should apply to claims filed before the effective date. The commenter also said that we should apply the proposed new policies about decisions from other governmental agencies and nongovernmental entities and about statements on issues reserved to the Commissioner to all claims.

Response: We carefully considered these comments and decided to implement these final rules consistent with our proposed implementation process. We are aware that individuals who filed claims before the effective date of these final rules may have requested evidence, including medical opinions from ''treating sources,'' based on our current policies. We are also cognizant that some of our existing rules may have engendered reliance interests that we need to consider. We proposed to implement some of these rules differently from our usual practice in recognition of these factors, which we believe still apply. However, to help adjudicators identify which rules they should follow, we revised the titles and introductory text in final 404.1520c, 404.1527, 416.920c, and 416.927.

Comment: A commenter stated that some of the changes proposed in the NPRM were not evidence-based or supported by ''current data.'' The commenter also raised concern about the speed and accuracy of disability determinations that we would make under the proposed rules, although the commenter did not specify which policies were of concern.

Response: We appreciate and agree with the commenter's desire for evidence-based policies, and for efficient, fair, and policy-compliant disability determinations. We have explained at length in the preamble the reasons and the support for the policy changes. The primary reason that we are updating our rules is to reflect the current ways in which people receive medical treatment. As we implement these final rules, we will continue our current internal procedures for monitoring the quality and quantity of determinations to ensure that adjudicators continue to apply our rules timely and accurately.

Comment: One commenter asserted that we are required to include an analysis under the Regulatory Flexibility Act because the proposals would have a significant economic impact on a substantial number of small entities, such as law firms and non-profit organizations.

Response: We did not adopt this comment because we are only required to perform a Regulatory Flexibility Act analysis if small entities will be subject to the proposed rule. The comment did not explain how these final rules may have a significant economic impact on a substantial number of small entities. ''Congress 'did not intend to require that every agency consider every indirect effect that any regulation might have on small businesses in any stratum of the national economy.'' [71] Only individuals may receive disability or blindness benefits under titles II and XVI of the Act. An individual who applies for disability or blindness benefits may enter into an agreement with an individual representative to help him or her with the claim, which may include a fee for services provided.[72] However, our current regulations do not recognize any entities as representatives.[73] Therefore, as authorized by the Regulatory Flexibility Act,[74] we correctly certified below that these final rules will not have a significant economic impact on a substantial number of small entities because they affect individuals only.

Comment: Several commenters stated that the proposed rules would not make our decisions more accurate or decrease the time it takes for us to adjudicate a claim. These commenters also asserted that the proposed rules would create more appeals and delays.

[69] Current 416.903(f).

[70] Current 404.1617(c) and 416.1017(c).

[71] *Cement Kiln Recycling Coalition* v. *Environmental Protection Agency,* 255 F.3d 855, 869 (D.C. Cir. 2001) (quoting *Mid-Texas Electrical Cooperative, Inc.* v. *Federal Energy Regulatory Commission,* 773 F.3d 327, 343 (D.C. Cir. 1985)).

[72] See current 404.1720 and 416.1520.

[73] See current 404.1705 and 416.1505.

[74] 5 U.S.C. 605(b).

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Response: We disagree that these rules will make our decisions less accurate or will increase the time it takes for us to adjudicate a claim. These final rules clarify some existing policies and revise others for increased transparency and balance. As we discussed at length above, we expect that the changes we are adopting in these final rules will further the fair and timely administration of our programs. We have made a number of changes to the proposed rules to address concerns raised by commenters about aspects of the proposed rules, and to enhance our goal of ensuring that we adjudicate claims fairly, accurately, and in a timely manner.

Executive Order 12866, as Supplemented by Executive Order 13563

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

Regulatory Flexibility Act

We certify that these final rules will not have a significant economic impact on a substantial number of small entities because they affect individuals only. Therefore, a regulatory flexibility analysis is not required under the Regulatory Flexibility Act, as amended.

Paperwork Reduction Act

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

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

List of Subjects

20 CFR Part 404

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

20 CFR Part 416

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

Carolyn W. Colvin,

Acting Commissioner of Social Security.

For the reasons set out in the preamble, we are amending part 404 subparts J, P, and Q, and part 416 subparts I, J, and N as set forth below:

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

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

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

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

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

§ 404.906 Testing modifications to the disability determination procedures.

* * * * *

(b) * * *

(2) * * * However, before an initial determination is made in any case where there is evidence which indicates the existence of a mental impairment, the decisionmaker will make every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment pursuant to our existing procedures (see § 404.1617). * * *

* * * * *

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

§ 404.942 Prehearing proceedings and decisions by attorney advisors.

* * * * *

(f) * * *

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

* * * * *

Subpart P—Determining Disability and Blindness

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

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

■ 5. Revise § 404.1502 to read as follows:

§ 404.1502 Definitions for this subpart.

As used in the subpart—

Acceptable medical source means a medical source who is a:

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

(2) Licensed psychologist, which includes:

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

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

(3) Licensed optometrist for impairments of visual disorders, or measurement of visual acuity and visual fields only, depending on the scope of practice in the State in which the optometrist practices;

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

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

(6) Licensed audiologist for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only (with respect to claims filed (see § 404.614) on or after March 27, 2017);

(7) Licensed Advanced Practice Registered Nurse, or other licensed advanced practice nurse with another title, for impairments within his or her licensed scope of practice (only with respect to claims filed (see § 404.614) on or after March 27, 2017); or

(8) Licensed Physician Assistant for impairments within his or her licensed

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scope of practice (only with respect to claims filed (see § 404.614) on or after March 27, 2017).

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

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

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

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

(1) You;

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

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

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

Objective medical evidence means signs, laboratory findings, or both.

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

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

Symptoms means your own description of your physical or mental impairment.

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

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

§ 404.1503 [Amended]

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

■ 7. Revise § 404.1504 to read as follows:

§ 404.1504 Decisions by other governmental agencies and nongovernmental entities.

Other governmental agencies and nongovernmental entities—such as the Department of Veterans Affairs, the Department of Defense, the Department of Labor, the Office of Personnel Management, State agencies, and private insurers— make disability, blindness, employability, Medicaid, workers' compensation, and other benefits decisions for their own programs using their own rules. Because a decision by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits is based on its rules, it is not binding on us and is not our decision about whether you are disabled or blind under our rules. Therefore, in claims filed (see § 404.614) on or after March 27, 2017, we will not provide any analysis in our determination or decision about a decision made by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits. However, we will consider all of the supporting evidence underlying the other governmental agency or nongovernmental entity's decision that we receive as evidence in your claim in accordance with § 404.1513(a)(1) through(4).

§ 404.1508 [Removed and reserved]

■ 8. Remove and reserve § 404.1508.

■ 9. Revise § 404.1512 to read as follows:

§ 404.1512 Responsibility for evidence.

(a) *Your responsibility.*

(1) *General.* In general, you have to prove to us that you are blind or disabled. You must inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled (*see* § 404.1513). This duty is ongoing and requires you to disclose any additional related evidence about which you become aware. This duty applies at each level of the administrative review process, including the Appeals Council level if the evidence relates to the period on or before the date of the administrative law judge hearing decision. We will consider only impairment(s) you say you have or about which we receive evidence. When you submit evidence received from another source, you must submit that evidence in its entirety, unless you previously submitted the same evidence to us or we instruct you otherwise. If we ask you, you must inform us about:

(i) Your medical source(s);

(ii) Your age;

(iii) Your education and training;

(iv) Your work experience;

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

(vi) Your efforts to work; and

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

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

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

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

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

(b) *Our responsibility.*

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

(i) *Every reasonable effort* means that we will make an initial request for evidence from your medical source or entity that maintains your medical source's evidence, and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one

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follow-up request to obtain the medical evidence necessary to make a determination. The medical source or entity that maintains your medical source's evidence will have a minimum of 10 calendar days from the date of our follow-up request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case.

(ii) *Complete medical history* means the records of your medical source(s) covering at least the 12 months preceding the month in which you file your application. If you say that your disability began less than 12 months before you filed your application, we will develop your complete medical history beginning with the month you say your disability began unless we have reason to believe your disability began earlier. If applicable, we will develop your complete medical history for the 12-month period prior to the month you were last insured for disability insurance benefits (see § 404.130), the month ending the 7-year period you may have to establish your disability and you are applying for widow's or widower's benefits based on disability (see § 404.335(c)(1)), or the month you attain age 22 and you are applying for child's benefits based on disability (see § 404.350).

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

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

■ 10. Revise § 404.1513 to read as follows:

§ 404.1513 Categories of evidence.

(a) *What we mean by evidence.* Subject to the provisions of paragraph (b), evidence is anything you or anyone else submits to us or that we obtain that relates to your claim. We consider evidence under §§ 404.1520b, 404.1520c (or under § 404.1527 for claims filed (see § 404.614) before March 27, 2017). We evaluate evidence we receive according to the rules pertaining to the relevant category of evidence. The categories of evidence are:

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

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

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

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

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

(iv) Your ability to adapt to environmental conditions, such as temperature extremes or fumes. (For claims filed (see § 404.614) before March 27, 2017, see § 404.1527(a) for the definition of medical opinion.)

(3) *Other medical evidence.* Other medical evidence is evidence from a medical source that is not objective medical evidence or a medical opinion, including judgments about the nature and severity of your impairments, your medical history, clinical findings, diagnosis, treatment prescribed with response, or prognosis. (For claims filed (see § 404.614) before March 27, 2017, *other medical evidence* does not include a diagnosis, prognosis, or a statement that reflects a judgment(s) about the nature and severity of your impairment(s)).

(4) *Evidence from nonmedical sources.* Evidence from nonmedical sources is any information or statement(s) from a nonmedical source (including you) about any issue in your claim. We may receive evidence from nonmedical sources either directly from the nonmedical source or indirectly, such as from forms we receive and our administrative records.

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

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

(ii) The existence and severity of your symptoms;

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

(iv) Your residual functional capacity;

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

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

(b) *Exceptions for privileged communications.*

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

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

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

(2) The attorney-client privilege generally protects confidential communications between an attorney and his or her client that are related to providing or obtaining legal advice. The attorney work product doctrine generally protects an attorney's analyses, theories, mental impressions, and notes. In the context of your

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

■ 11. Add § 404.1513a to read as follows:

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

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

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

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

(2) When a State agency disability examiner makes the initial determination alone as provided in § 404.1615(c)(3), he or she may obtain medical evidence from a State agency medical or psychological consultant about one or more of the medical issues listed in paragraph (a)(1) of this section. In these cases, the State agency disability examiner will consider the medical evidence of the State agency medical or psychological consultant under §§ 404.1520b, 404.1520c, and 404.1527.

(3) When a State agency disability examiner makes a reconsideration determination alone as provided in § 404.1615(c)(3), he or she will consider prior administrative medical findings made by a State agency medical or psychological consultant at the initial level of the administrative review process, and any medical evidence provided by such consultants at the initial and reconsideration levels, about one or more of the medical issues listed in paragraph (a)(1)(i) of this section under §§ 404.1520b, 404.1520c, and 404.1527.

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

(1) Administrative law judges are not required to adopt any prior administrative medical findings, but they must consider this evidence according to §§ 404.1520b, 404.1520c, and 404.1527, as appropriate, because our Federal or State agency medical or psychological consultants are highly qualified and experts in Social Security disability evaluation.

(2) Administrative law judges may also ask for medical evidence from expert medical sources. Administrative law judges will consider this evidence under §§ 404.1520b, 404.1520c, and 404.1527, as appropriate.

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

■ 12. Revise § 404.1518 (c) to read as follows:

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

* * * * *

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

■ 13. Revise § 404.1519g (a) to read as follows:

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

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

* * * * *

■ 14. Revise § 404.1519h to read as follows:

§ 404.1519h Your medical source.

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

■ 15. Revise § 404.1519i to read as follows:

§ 404.1519i Other sources for consultative examinations.

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

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

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

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

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

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

■ 16. Revise § 404.1519n(c)(6) to read as follows:

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

* * * * *

(c) * * *

(6) *A medical opinion.* Although we will ordinarily request a medical opinion as part of the consultative examination process, the absence of a medical opinion in a consultative examination report will not make the report incomplete. See § 404.1513(a)(3); and

* * * * *

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

§ 404.1520a Evaluation of mental impairments.

* * * * *

(b) * * *

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

* * * * *

(d) * * *

(1) If we rate the degrees of your limitation as ''none'' or ''mild,'' we will generally conclude that your impairment(s) is not severe, unless the evidence otherwise indicates that there is more than a minimal limitation in your ability to do basic work activities (see § 404.1522).

* * * * *

■ 18. Revise § 404.1520b to read as follows:

§ 404.1520b How we consider evidence.

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

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

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

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

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

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

(ii) We may request additional existing evidence;

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

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

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

(c) *Evidence that is inherently neither valuable nor persuasive.* Paragraphs (c)(1) through (c)(3) apply in claims filed (see § 404.614) on or after March 27, 2017. Because the evidence listed in paragraphs (c)(1) through (c)(3) of this section is inherently neither valuable nor persuasive to the issue of whether you are disabled or blind under the Act, we will not provide any analysis about how we considered such evidence in our determination or decision, even under § 404.1520c:

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

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

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

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

(ii) Statements about whether or not you have a severe impairment(s);

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

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

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

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

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

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

■ 19. Add § 404.1520c to read as follows:

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

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

(a) *How we consider medical opinions and prior administrative medical findings.* We will not defer or give any specific evidentiary weight, including

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controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources. When a medical source provides one or more medical opinions or prior administrative medical findings, we will consider those medical opinions or prior administrative medical findings from that medical source together using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. The most important factors we consider when we evaluate the persuasiveness of medical opinions and prior administrative medical findings are supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section). We will articulate how we considered the medical opinions and prior administrative medical findings in your claim according to paragraph (b) of this section.

(b) *How we articulate our consideration of medical opinions and prior administrative medical findings.* We will articulate in our determination or decision how persuasive we find all of the medical opinions and all of the prior administrative medical findings in your case record. Our articulation requirements are as follows:

(1) *Source-level articulation.* Because many claims have voluminous case records containing many types of evidence from different sources, it is not administratively feasible for us to articulate in each determination or decision how we considered all of the factors for all of the medical opinions and prior administrative medical findings in your case record. Instead, when a medical source provides multiple medical opinion(s) or prior administrative medical finding(s), we will articulate how we considered the medical opinions or prior administrative medical findings from that medical source together in a single analysis using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. We are not required to articulate how we considered each medical opinion or prior administrative medical finding from one medical source individually.

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

(3) *Equally persuasive medical opinions or prior administrative medical findings about the same issue.* When we find that two or more medical opinions or prior administrative medical findings about the same issue are both equally well-supported (paragraph (c)(1) of this section) and consistent with the record (paragraph (c)(2) of this section) but are not exactly the same, we will articulate how we considered the other most persuasive factors in paragraphs (c)(3) through (c)(5) of this section for those medical opinions or prior administrative medical findings in your determination or decision.

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

(1) *Supportability.* The more relevant the objective medical evidence and supporting explanations presented by a medical source are to support his or her medical opinion(s) or prior administrative medical finding(s), the more persuasive the medical opinions or prior administrative medical finding(s) will be.

(2) *Consistency.* The more consistent a medical opinion(s) or prior administrative medical finding(s) is with the evidence from other medical sources and nonmedical sources in the claim, the more persuasive the medical opinion(s) or prior administrative medical finding(s) will be.

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

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

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

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

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

(v) *Examining relationship.* A medical source may have a better understanding of your impairment(s) if he or she examines you than if the medical source only reviews evidence in your folder.

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

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

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

■ 20. Revise § 404.1521 to read as follows:

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

If you are not doing substantial gainful activity, we will then determine whether you have a medically determinable physical or mental impairment(s) (see § 404.1520(a)(4)(ii)). Your impairment(s) must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Therefore, a physical or mental impairment must be established by objective medical evidence from an

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

■ 21. Revise § 404.1522 to read as follows:

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

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

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

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

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

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

(4) Use of judgment;

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

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

■ 22. Revise § 404.1523 to read as follows:

§ 404.1523 Multiple impairments.

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

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

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

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

§ 404.1525 Listing of Impairments in appendix 1.

* * * * *

(c) * * *

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

* * * * *

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

§ 404.1526 Medical equivalence.

* * * * *

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

(e) *Who is responsible for determining medical equivalence?*

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

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

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

■ 25. Revise § 404.1527 to read as follows:

§ 404.1527 Evaluating opinion evidence for claims filed before March 27, 2017.

For claims filed (see § 404.614) before March 27, 2017, the rules in this section apply. For claims filed on or after March 27, 2017, the rules in § 404.1520c apply.

(a) *Definitions.*

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

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

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

(c) *How we weigh medical opinions.* Regardless of its source, we will

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

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

(2) *Treatment relationship.* Generally, we give more weight to medical opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's medical opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's medical opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors in paragraphs (c)(3) through (c)(6) of this section in determining the weight to give the medical opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's medical opinion.

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

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

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

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

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

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

(d) *Medical source opinions on issues reserved to the Commissioner.* Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(1) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; *i.e.,* that would direct the determination or decision of disability.

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

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

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

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

(f) *Opinions from medical sources who are not acceptable medical sources and from nonmedical sources.*

(1) *Consideration.* Opinions from medical sources who are not acceptable medical sources and from nonmedical sources may reflect the source's judgment about some of the same issues addressed in medical opinions from acceptable medical sources. Although we will consider these opinions using the same factors as listed in paragraph (c)(1) through (c)(6) in this section, not every factor for weighing opinion evidence will apply in every case because the evaluation of an opinion from a medical source who is not an acceptable medical source or from a nonmedical source depends on the

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particular facts in each case. Depending on the particular facts in a case, and after applying the factors for weighing opinion evidence, an opinion from a medical source who is not an acceptable medical source or from a nonmedical source may outweigh the medical opinion of an acceptable medical source, including the medical opinion of a treating source. For example, it may be appropriate to give more weight to the opinion of a medical source who is not an ''acceptable medical source'' if he or she has seen the individual more often than the treating source, has provided better supporting evidence and a better explanation for the opinion, and the opinion is more consistent with the evidence as a whole.

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

§ 404.1528 [Removed and Reserved]

■ 26. Remove and reserve § 404.1528.

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

§ 404.1529 How we evaluate symptoms, including pain.

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

* * * * *

(c) * * *

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

* * * * *

(3) *Consideration of other evidence.* Because symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. The information that your medical sources or nonmedical sources provide about your pain or other symptoms (*e.g.,* what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions that your medical sources or nonmedical sources report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your medical sources, and observations by our employees and other persons. Section 404.1520c explains in detail how we consider medical opinions and prior administrative medical findings about the nature and severity of your impairment(s) and any related symptoms, such as pain. Factors relevant to your symptoms, such as pain, which we will consider include:

* * * * *

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

* * * * *

■ 28. Revise § 404.1530(a) to read as follows:

§ 404.1530 Need to follow prescribed treatment.

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

* * * * *

■ 29. Amend § 404.1579 by revising the second sentence of paragraph (b)(1) and the second sentence of paragraph (b)(4) to read as follows:

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

* * * * *

(b) * * *

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

* * * * *

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

* * * * *

■ 30. Amend § 404.1594 by revising the second sentence of paragraph (b)(1), the sixth sentence in Example 1, the second sentence of paragraph (b)(6), and the fourth sentence of paragraph (c)(3)(v) to read as follows:

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

* * * * *

(b) * * *

(1) * * * A determination that there has been a decrease in medical severity

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must be based on improvement in the symptoms, signs, and/or laboratory findings associated with your impairment(s).

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

* * * * *

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

* * * * *

(c) * * *

(3) * * *

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

* * * * *

■ 31. Amend *Appendix 1 to subpart P of part 404*as follows:

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

■ b. Revise 2.00B.1.b;

■ c. Revise 2.00B.1.c;

■ d. Revise the fourth sentence of 7.00H;

■ e. Revise the second sentence of 8.00C.3;

■ f. Revise the first sentence 8.00E.3.a;

■ g. Revise 12.00C.1;

■ h. Revise the fourth sentence of 14.00H;

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

■ j. Revise 102.00B.1.b;

■ k. Revise 102.00B.1.c;

■ l. Revise the fourth sentence of 107.00G;

■ m. Revise the second sentence of 108.00C.3.;

■ n. Revise the first sentence 108.00E.3.a;

■ o. Revise 112.00.C.1;

■ p. Revise the fourth sentence of 114.00H.

The revisions read as follows:

Appendix 1 to Subpart P of Part 404—

2.00 * * *

B. * * *

1. * * *

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

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

c. Audiometric testing must be performed by, or under the direct supervision of, a licensed audiologist or an otolaryngologist.

* * * * *

7.00 * * *

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

* * * * *

8.00 * * *

C. * * *

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

* * * * *

E. * * *

3. * * *

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

12.00 * * *

C. * * *

1. *General.* We need objective medical evidence from an acceptable medical source to establish that you have a medically determinable mental disorder. We also need evidence to assess the severity of your mental disorder and its effects on your ability to function in a work setting. We will determine the extent and kinds of evidence we need from medical and nonmedical sources based on the individual facts about your disorder. For additional evidence requirements for intellectual disorder (12.05), see 12.00H. For our basic rules on evidence, see §§ 404.1512, 404.1513, 404.1520b, 416.912, 416.913, and 416.920b of this chapter. For our rules on evaluating medical opinions, see §§ 404.1520c, 404.1527, 416.920c, and 416.927 of this chapter. For our rules on evidence about your symptoms, see §§ 404.1529 and 416.929 of this chapter.

* * * * *

14.00 * * *

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

* * * * *

102.00 * * *

B. * * *

1. * * *

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

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

c. Audiometric testing must be performed by, or under the direct supervision of, a licensed audiologist or an otolaryngologist.

* * * * *

107.00 * * *

G. * * * (See sections 416.921 and 416.929 of this chapter.) * * *

* * * * *

108.00. * * *

C. * * *

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

* * * * *

E. * * *

3. * * *

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

* * * * *

112.00 * * *

C. * * *

1. *General.* We need objective medical evidence from an acceptable medical source to establish that you have a medically determinable mental disorder. We also need evidence to assess the severity of your mental disorder and its effects on your ability to function age-appropriately. We will determine the extent and kinds of evidence we need from medical and nonmedical sources based on the individual facts about your disorder. For additional evidence requirements for intellectual disorder (112.05), see 112.00H. For our basic rules on evidence, see §§ 416.912, 416.913, and 416.920b of this chapter. For our rules on evaluating medical opinions, see §§ 416.1520c and 416.927 of this chapter. For our rules on evidence about your symptoms, see § 416.929 of this chapter.

* * * * *

114.00 * * *

H. * * * See §§ 416.921 and 416.929.

* * *

* * * * *

Subpart Q—Determinations of Disability

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

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

§ 404.1615 [Amended]

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

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■ 34. Revise § 404.1616 to read as follows:

§ 404.1616 Medical consultants and psychological consultants.

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

(b) *What qualifications must a medical consultant have?* A medical consultant is a licensed physician, as defined in § 404.1502(a)(1).

(c) *What is a psychological consultant?* A psychological consultant is a member of a team that makes disability determinations in a State agency (see § 404.1615), or who is a member of a team that makes disability determinations for us when we make disability determinations ourselves. The psychological consultant completes the medical portion of the case review and any applicable residual functional capacity assessment about all mental impairment(s) in a claim. When we are unable to obtain the services of a qualified psychiatrist or psychologist despite making every reasonable effort (see § 404.1617) in a claim involving a mental impairment(s), a medical consultant will evaluate the mental impairment(s).

(d) *What qualifications must a psychological consultant have?* A psychological consultant can be either a licensed psychiatrist or psychologist. We will only consider a psychologist qualified to be a psychological consultant if he or she:

(1) Is licensed or certified as a psychologist at the independent practice level of psychology by the State in which he or she practices; and

(2)(i) Possesses a doctorate degree in psychology from a program in clinical psychology of an educational institution accredited by an organization recognized by the Council on Post-Secondary Accreditation; or

(ii) Is listed in a national register of health service providers in psychology which the Commissioner of Social Security deems appropriate; and

(3) Possesses 2 years of supervised clinical experience as a psychologist in health service, at least 1 year of which is post-masters degree.

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

■ 35. In § 404.1617, revise the section heading and paragraph (a) to read as follows:

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

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

* * * * *

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

Subpart I—Determining Disability and Blindness

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

Authority: Secs. 221(m), 702(a)(5), 1611, 1614, 1619, 1631(a), (c), (d)(1), and (p), and 1633 of the Social Security Act (42 U.S.C. 421(m), 902(a)(5), 1382, 1382c, 1382h, 1383(a), (c), (d)(1), and (p), and 1383b); secs. 4(c) and 5, 6(c)–(e), 14(a), and 15, Pub. L. 98–460, 98 Stat. 1794, 1801, 1802, and 1808 (42 U.S.C. 421 note, 423 note, and 1382h note).

■ 37. Revise § 416.902 to read as follows:

§ 416.902 Definitions for this subpart.

As used in the subpart—

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

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

(2) Licensed psychologist, which includes:

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

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

(3) Licensed optometrist for impairments of visual disorders, or measurement of visual acuity and visual fields only, depending on the scope of practice in the State in which the optometrist practices;

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

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

(6) Licensed audiologist for impairments of for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only (with respect to claims filed (see § 416.325) on or after March 27, 2017);

(7) Licensed Advanced Practice Registered Nurse, or other licensed advanced practice nurse with another title, for impairments within his or her licensed scope of practice (only with respect to claims filed (see § 416.325) on or after March 27, 2017); or

(8) Licensed Physician Assistant for impairments within his or her licensed scope of practice (only with respect to claims filed (see § 416.325) on or after March 27, 2017).

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

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

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

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

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

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

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

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

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

(1) You;

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

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

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

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

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

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

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

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

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

(q) *You, your, me, my* and *I* mean, as appropriate, the person who applies for benefits, the person for whom an application is filed, or the person who is receiving benefits based on disability or blindness.

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

§ 416.903 Who makes disability and blindness determinations.

* * * * *

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

■ 39. Revise § 416.904 to read as follows:

§ 416.904 Decisions by other governmental agencies and nongovernmental ties.

Other governmental agencies and nongovernmental entities—such as the Department of Veterans Affairs, the Department of Defense, the Department of Labor, the Office of Personnel Management, State agencies, and private insurers—make disability, blindness, employability, Medicaid, workers' compensation, and other benefits decisions for their own programs using their own rules. Because a decision by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits is based on its rules, it is not binding on us and is not our decision about whether you are disabled or blind under our rules. Therefore, in claims filed (see § 416.325) on or after March 27, 2017, we will not provide any analysis in our determination or decision about a decision made by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits. However, we will consider all of the supporting evidence underlying the other governmental agency or nongovernmental entity's decision that we receive as evidence in your claim in accordance with § 416.913(a)(1) through (4).

§ 416.908 [Removed and reserved].

■ 40. Remove and reserve § 416.908.

■ 41. Revise § 416.912 to read as follows:

§ 416.912 Responsibility for evidence.

(a) *Your responsibility.*

(1) *General.* In general, you have to prove to us that you are blind or disabled. You must inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled (*see* § 416.913). This duty is ongoing and requires you to disclose any additional related evidence about

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

(i) Your medical source(s);

(ii) Your age;

(iii) Your education and training;

(iv) Your work experience;

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

(vi) Your efforts to work; and

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

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

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

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

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

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

(b) *Our responsibility.*

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

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

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

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

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

■ 42. Revise § 416.913 to read as follows:

§ 416.913 Categories of evidence.

(a) *What we mean by evidence.* Subject to the provisions of paragraph (b), evidence is anything you or anyone else submits to us or that we obtain that relates to your claim. We consider evidence under §§ 416.920b, 416.920c (or under § 416.927 for claims filed (see § 416.325) before March 27, 2017). We evaluate evidence we receive according to the rules pertaining to the relevant category of evidence. The categories of evidence are:

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

(2) *Medical opinion.* A medical opinion is a statement from a medical source about what you can still do despite your impairment(s) and whether you have one or more impairment-related limitations or restrictions in the abilities listed in paragraphs (a)(2)(i)(A) through (D) and (a)(2)(ii)(A) through (F) of this section. (For claims filed (see § 416.325) before March 27, 2017, see § 416.927(a) for the definition of medical opinion.)

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

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

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

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

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

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

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

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

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

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

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

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

(3) *Other medical evidence.* Other medical evidence is evidence from a medical source that is not objective medical evidence or a medical opinion, including judgments about the nature and severity of your impairments, your medical history, clinical findings, diagnosis, treatment prescribed with response, or prognosis. (For claims filed (see § 416.325) before March 27, 2017, *other medical evidence* does not include a diagnosis, prognosis, or a statement that reflects a judgment(s) about the nature and severity of your impairment(s)).

(4) *Evidence from nonmedical sources.* Evidence from nonmedical sources is any information or statement(s) from a nonmedical source (including you) about any issue in your claim. We may receive evidence from nonmedical sources either directly from the nonmedical source or indirectly, such as from forms we receive and our administrative records.

(5) *Prior administrative medical finding.* A prior administrative medical finding is a finding, other than the ultimate determination about whether you are disabled, about a medical issue made by our Federal and State agency medical and psychological consultants at a prior level of review (see § 416.1400) in your current claim based on their review of the evidence in your case record, such as:

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

(ii) The existence and severity of your symptoms;

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

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

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

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

(vii) How failure to follow prescribed treatment (see § 416.930) and drug addiction and alcoholism (see § 416.935) relate to your claim.

(b) *Exceptions for privileged communications.*

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

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

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

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

■ 43. Add § 416.913a to read as follows:

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

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

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

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

(2) When a State agency disability examiner makes the initial determination alone as provided in § 416.1015(c)(3), he or she may obtain medical evidence from a State agency medical or psychological consultant about one or more of the medical issues listed in paragraph (a)(1) of this section. In these cases, the State agency disability examiner will consider the medical evidence of the State agency medical or psychological consultant under §§ 416.920b, 416.920c, and 416.927.

(3) When a State agency disability examiner makes a reconsideration determination alone as provided in § 416.1015(c)(3), he or she will consider prior administrative medical findings made by a State agency medical or psychological consultant at the initial level of the administrative review process, and any medical evidence provided by such consultants at the initial and reconsideration levels, about one or more of the medical issues listed in paragraph (a)(1)(i) of this section under §§ 416.920b, 416.920c, and 416.927.

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

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(1) Administrative law judges are not required to adopt any prior administrative medical findings, but they must consider this evidence according to §§ 416.920b, 416.920c, and 416.927, as appropriate, because our Federal or State agency medical or psychological consultants are highly qualified and experts in Social Security disability evaluation.

(2) Administrative law judges may also ask for medical evidence from expert medical sources. Administrative law judges will consider this evidence under §§ 416.920b, 416.920c, and 416.927, as appropriate.

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

■ 44. Revise § 416.918 paragraph (c) to read as follows:

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

* * * * *

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

■ 45. Revise § 416.919g(a) to read as follows:

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

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

* * * * *

■ 46. Revise § 416.919h to read as follows:

§ 416.919h Your medical source.

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

■ 47. Revise § 416.919i to read as follows:

§ 416.919i Other sources for consultative examinations.

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

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

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

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

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

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

■ 48. Revise § 416.919n paragraph (c)(6) to read as follows:

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

* * * * *

(c) * * *

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

* * * * *

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

§ 416.920a Evaluation of mental impairments.

* * * * *

(b) * * *

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

* * * * *

(d) * * *

(1) If we rate the degrees of your limitation as ''none'' or ''mild,'' we will generally conclude that your impairment(s) is not severe, unless the evidence otherwise indicates that there is more than a minimal limitation in your ability to do basic work activities (see § 416.922).

* * * * *

■ 50. Revise § 416.920b to read as follows:

§ 416.920b How we consider evidence.

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

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

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

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

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

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

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(ii) We may request additional existing evidence;

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

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

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

(c) *Evidence that is inherently neither valuable nor persuasive.* Paragraphs (c)(1) through (c)(3) apply in claims filed (see § 416.325) on or after March 27, 2017. Because the evidence listed in paragraphs ((c)(1)–(c)(3) of this section is inherently neither valuable nor persuasive to the issue of whether you are disabled or blind under the Act, we will not provide any analysis about how we considered such evidence in our determination or decision, even under § 416.920c:

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

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

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

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

(ii) Statements about whether or not you have a severe impairment(s);

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

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

(v) If you are a child, statements about whether or not your impairment(s) functionally equals the listings in Part 404 Subpart P Appendix 1 (see § 416.926a);

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

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

(viii) If you are an adult, statements that you do or do not meet the requirements of a medical-vocational rule in Part 404, Subpart P, Appendix 2; and

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

■ 51. Add § 416.920c to read as follows:

§ 416.920c How we consider and articulate medical opinions and prior administrative medical findings for claims filed on or after March 27, 2017.

For claims filed (see § 416.325) on or after March 27, 2017, the rules in this section apply. For claims filed before March 27, 2017, the rules in § 416.927 apply.

(a) *How we consider medical opinions and prior administrative medical findings.* We will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources. When a medical source provides one or more medical opinions or prior administrative medical findings, we will consider those medical opinions or prior administrative medical findings from that medical source together using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. The most important factors we consider when we evaluate the persuasiveness of medical opinions and prior administrative medical findings are supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section). We will articulate how we considered the medical opinions and prior administrative medical findings in your claim according to paragraph (b) of this section.

(b) *How we articulate our consideration of medical opinions and prior administrative medical findings.* We will articulate in our determination or decision how persuasive we find all of the medical opinions and all of the prior administrative medical findings in your case record. Our articulation requirements are as follows:

(1) *Source-level articulation.* Because many claims have voluminous case records containing many types of evidence from different sources, it is not administratively feasible for us to articulate in each determination or decision how we considered all of the factors for all of the medical opinions and prior administrative medical findings in your case record. Instead, when a medical source provides multiple medical opinion(s) or prior administrative medical finding(s), we will articulate how we considered the medical opinions or prior administrative medical findings from that medical source together in a single analysis using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. We are not required to articulate how we considered each medical opinion or prior administrative medical finding from one medical source individually.

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

(3) *Equally persuasive medical opinions or prior administrative medical findings about the same issue.* When we find that two or more medical opinions or prior administrative medical findings about the same issue are both equally well-supported (paragraph (c)(1) of this section) and consistent with the record (paragraph (c)(2) of this section) but are not exactly the same, we will articulate how we considered the other most persuasive factors in paragraphs (c)(3) through (c)(5) of this section for those medical opinions or prior administrative medical findings in your determination or decision.

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

(1) *Supportability.* The more relevant the objective medical evidence and supporting explanations presented by a medical source are to support his or her medical opinion(s) or prior

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administrative medical finding(s), the more persuasive the medical opinions or prior administrative medical finding(s) will be.

(2) *Consistency.* The more consistent a medical opinion(s) or prior administrative medical finding(s) is with the evidence from other medical sources and nonmedical sources in the claim, the more persuasive the medical opinion(s) or prior administrative medical finding(s) will be.

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

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

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

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

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

(v) *Examining relationship.* A medical source may have a better understanding of your impairment(s) if he or she examines you than if the medical source only reviews evidence in your folder.

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

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

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

■ 52. Revise § 416.921 to read as follows:

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

If you are not doing substantial gainful activity, we will then determine whether you have a medically determinable physical or mental impairment(s) (see § 416.920(a)(4)(ii)). Your impairment(s) must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Therefore, a physical or mental impairment must be established by objective medical evidence from an acceptable medical source. We will not use your statement of symptoms, a diagnosis, or a medical opinion to establish the existence of an impairment(s). After we establish that you have a medically determinable impairment(s), then we determine whether your impairment(s) is severe.

■ 53. Revise § 416.922 to read as follows:

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

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

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

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

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

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

(4) Use of judgment;

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

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

■ 54. Revise § 416.923 to read as follows:

§ 416.923 Multiple impairments.

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

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

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

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

§ 416.924a Considerations in determining disability for children.

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

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(1) * * *

(i) * * * (*See* § 416.920c.)

* * * * *

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

(2) *Statements from nonmedical sources.* * * *

* * * * *

■ 56. Amend § 416.924b by revising the first sentence of paragraph (b)(3) to read as follows:

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

* * * * *

(b) * * *

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

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

§ 416.925 Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter.

* * * * *

(c) * * *

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

* * * * *

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

§ 416.926 Medical equivalence for adults and children.

* * * * *

(d) *Who is a designated medical or psychological consultant?* A medical or psychological consultant designated by the Commissioner includes any medical or psychological consultant employed or engaged to make medical judgments by the Social Security Administration, the Railroad Retirement Board, or a State agency authorized to make disability determinations. See § 416.1016 of this part for the necessary qualifications for medical consultants and psychological consultants and the limitations on what medical consultants who are not physicians can evaluate.

(e) *Who is responsible for determining medical equivalence?*

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

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

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

■ 59. Amend § 416.926a by revising the second sentence of paragraph (b)(3) to read as follows:

§ 416.926a Functional equivalence for children.

* * * * *

(b) * * *

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

* * * * *

■ 60. Revise § 416.927 to read as follows:

§ 416.927 Evaluating opinion evidence for claims filed before March 27, 2017.

For claims filed (see § 416.325) before March 27, 2017, the rules in this section apply. For claims filed on or after March 27, 2017, the rules in § 416.920c apply.

(a) *Definitions.*

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) *Medical source opinions on issues reserved to the Commissioner.* Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(1) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; *i.e.,* that would direct the determination or decision of disability.

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

(2) *Other opinions on issues reserved to the Commissioner.* We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to subpart P of part 404 of this chapter, your residual functional capacity (see §§ 416.945 and 416.946), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

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

(e) *Evidence from our Federal or State agency medical or psychological consultants.* The rules in § 416.913a apply except that when an administrative law judge gives controlling weight to a treating source's medical opinion, the administrative law judge is not required to explain in the decision the weight he or she gave to the prior administrative medical findings in the claim.

(f) *Opinions from medical sources who are not acceptable medical sources and from nonmedical sources.*

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

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

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initial and reconsideration levels, if the determination is less than fully favorable.

§ 416.928 [Removed and Reserved]

■ 61. Remove and reserve § 416.928.

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

§ 416.929 How we evaluate symptoms, including pain.

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

* * * * *

(c) * * *

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

* * * * *

(3) *Consideration of other evidence.* Because symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. The information that your medical sources or nonmedical sources provide about your pain or other symptoms (*e.g.,* what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions that your medical sources or nonmedical sources report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your medical sources, and observations by our employees and other persons. If you are a child, we will also consider all of the evidence presented, including evidence submitted by your medical sources (such as physicians, psychologists, and therapists) and nonmedical sources (such as educational agencies and personnel, parents and other relatives, and social welfare agencies). Section 416.920c explains in detail how we consider medical opinions and prior administrative medical findings about the nature and severity of your impairment(s) and any related symptoms, such as pain. Factors relevant to your symptoms, such as pain, which we will consider include:

* * * * *

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

* * * * *

■ 63. Revise § 416.930(a) to read as follows:

§ 416.930 Need to follow prescribed treatment.

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

* * * * *

■ 64. Amend § 416.993 by revising the seventh and ninth sentences of paragraph (b) to read as follows:

§ 416.993 Medical evidence in continuing disability review cases.

* * * * *

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

* * * * *

■ 65. Amend § 416.994 by revising the last sentence in paragraph (b)(1)(i), the sixth sentence in example 1, the second sentence of paragraph (b)(1)(vi), and the fourth sentence of (b)(2)(iv)(E) to read as follows:

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

* * * * *

(b) * * *

(1) * * *

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

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

* * * * *

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

* * * * *

(2) * * *

(iv) * * *

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

■ 66. Amend § 416.994a by revising the second sentence of paragraph (a)(2), the first sentence in paragraph (c)(2), the fourth sentence of paragraph (d), and paragraph (i)(1) to read as follows:

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

(a) * * *

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

* * * * *

(c) * * *

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

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

* * * * *

(i) * * *

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

* * * * *

Subpart J—Determinations of Disability

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

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

§ 416.1015 [Amended]

■ 68. Revise § 416.1015 by removing paragraph (d) and redesignating paragraphs (e) through (h) as paragraphs (d) through (g).

■ 69. Revise § 416.1016 to read as follows:

§ 416.1016 Medical consultants and psychological consultants.

(a) *What is a medical consultant?* A medical consultant is a member of a team that makes disability determinations in a State agency (see § 416.1015), or who is a member of a team that makes disability determinations for us when we make disability determinations ourselves. The medical consultant completes the medical portion of the case review and any applicable residual functional capacity assessment about all physical impairment(s) in a claim.

(b) *What qualifications must a medical consultant have?* A medical consultant is a licensed physician, as defined in § 416.902(a)(1).

(c) *What is a psychological consultant?* A psychological consultant is a member of a team that makes disability determinations in a State agency (see § 416.1015), or who is a member of a team that makes disability determinations for us when we make disability determinations ourselves. The psychological consultant completes the medical portion of the case review and any applicable residual functional capacity assessment about all mental impairment(s) in a claim. When we are unable to obtain the services of a qualified psychiatrist or psychologist despite making every reasonable effort (see § 416.1017) in a claim involving a mental impairment(s), a medical consultant will evaluate the mental impairment(s).

(d) *What qualifications must a psychological consultant have?* A psychological consultant can be either a licensed psychiatrist or psychologist. We will only consider a psychologist qualified to be a psychological consultant if he or she:

(1) Is licensed or certified as a psychologist at the independent practice level of psychology by the State in which he or she practices; and

(2)(i) Possesses a doctorate degree in psychology from a program in clinical psychology of an educational institution accredited by an organization recognized by the Council on Post-Secondary Accreditation; or

(ii) Is listed in a national register of health service providers in psychology which the Commissioner of Social Security deems appropriate; and

(3) Possesses 2 years of supervised clinical experience as a psychologist in health service, at least 1 year of which is post-masters degree.

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

■ 70. Revise § 416.1017(a) to read as follows:

§ 416.1017 Reasonable efforts to obtain review by a qualified psychiatrist or psychologist.

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

* * * * *

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

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

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

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

§ 416.1406 Testing modifications to the disability determination procedures.

* * * * *

(b) * * *

(2) * * * However, before an initial determination is made in any case where there is evidence which indicates the existence of a mental impairment, the decisionmaker will make every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of

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the case review and any applicable residual functional capacity assessment pursuant to our existing procedures (see § 416.1017). * * *

* * * * *

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

§ 416.1442 Prehearing proceedings and decisions by attorney advisors.

* * * * *

(f) * * *

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

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