

Memorandum

December 20, 2001

To: Cheryl Tucker, Social Insurance Programs Specialist
David Koons, Disability Programs Administrator

From: Drema Clark, Program Consultant, for Jane Johnstone, Director WV DDS

Subject: Comments on NPRM on Digestive System Listing

Several employees of the West Virginia DDS have read the NPRM published on November 14, 2001, *Revised Medical Criteria for Evaluating Impairments of the Digestive System*.

Most reviewers thought that the proposed revisions were reasonable and that the changes were needed. We like the expansion of the preamble of the listings and the elimination of reference listings. While overall we are pleased with the proposed revisions, we do have a few concerns.

Proposed 5.00 A and 105.00 A -- What Kind of Impairments Do We Consider in the Digestive System? One reviewer is concerned with elimination of any discussion of disorders and complications that SSA no longer always considers to result in listing-level severity. She suggests that the preamble to these listings include some discussion of how we will evaluate digestive impairments such as peptic ulcer disease and chronic pancreatitis for which there is no specific listing.

Proposed Listings 5.00 B. 1 and 105.00 B. 1 -- We are concerned with the impact on processing times. The first sentence of these two sections reads, "When we assess gastrointestinal or liver impairments, we usually need longitudinal evidence covering a period of at least 6 months of observations and treatment, unless we can make a fully favorable determination or decision without it." This will require the DDS to medically defer significant numbers of cases with documented impairments of the digestive system. While this will impact on both allowances and denials, we are most concerned with the impact on denied claims. With the current emphasis on denial accuracy, we are concerned that this will effectively mandate at least 6-months treatment records for all denied claims involving digestive impairments, even for those impairments that do not approach listing-level severity, e.g. peptic ulcer disease.

Proposed Listing 5.00 D.3. and 105.00 D.3. Nutritional Therapy -- Three of our medical consultants strongly disagree with the guidance in this section. They think that individuals who require parenteral or specialized enteral nutrition to avoid debilitating complications of a disease are not able to work and that this requirement, in and of itself, should indicate disability if the 12 month duration has been or is expected to be met. These individuals have IV or gastrostomy tubes, require special equipment, and frequently require multiple feedings a day which may require a significant amount of time. The consensus is that this is so intrusive these individuals cannot sustain work and that this should indicate listing - level severity.

Proposed 5.00 F.1. and 105.00 F.1. -- We suggest that the requirement that height be measured without shoes be incorporated into the preambles of the listings.

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Proposed Listing 5.05A -- One individual who reviewed the proposed changes questioned the requirement that there be transfusion of "at least 5 units of blood in 48 hours." He comments, "I do not believe specifying the number of units transfused can be supported. The size of the individual, protocol of the hospital, timeliness of intervention and probably other factors can influence the amount of blood transfused. I doubt the prognosis of an individual who has bleeding from esophageal varices and receives 4 units is significantly better than those receiving 5 units. Since physicians and hospitals are reluctant to transfuse blood, I suspect that any blood transfusion should suffice or the matter should at least be left to medical judgment."

Another reviewer was concerned with the requirement that there be 5 or more units of blood transfused in a 48 hour period. He stated that transfusion of *multiple* units of blood in conjunction with other interventions in an attempt to restore hemodynamic stability should suffice. There should be some latitude for medical judgment in this listing.

Proposed 5.05 B. 2 -- We do not think it is necessary to require that ascites be documented on physical examination *and* by appropriate medically acceptable imaging. Imaging studies are not always available. Also, since ascites can be documented by scan before it is apparent on physical exam, the scan seems to be unnecessary when the ascities is severe enough to be observed on physical examination and the serum albumin or prothrombin time criterion is fulfilled. In addition, we think that requiring prolongation of the prothrombin time of at least 2 seconds is medically unreasonable and may be excessive. Our MC thinks that any reading above the normal value (for the reporting laboratory) should qualify.

There is a typographical error on page 57020 of the *Federal Register* in the discussion under 105.00 E. 2. -- The third word of the first sentence, *haves*, should be *have*. (This is on page 26 of the PDF file.)

Proposed 105.05 B. 2 -- As in adult listing 5.05 B.2 we question the requirement that ascites be documented on physical examination *and* by appropriate medically acceptable imaging. Imaging studies are not always available, and as is pointed out in the preamble, ascites can be demonstrated by scan before it is extensive enough to be observed on physical exam. So, unless there is reason to question the examining source's judgment that ascites is present, we think the requirement that ascites be confirmed by both exam and imaging studies is excessive.

Proposed Listing 105.08 -- Should this listing or 105.00 F. specify that the most current edition of the CDC charts be used? In the past, there was confusion concerning which charts should be used to evaluate childhood claims involving growth impairments. Specifying that the latest edition be used would insure that the listing criteria reflected the latest guidance.

This completes our comments on the NPRM. Questions concerning this response may be addressed to me at (304) 353-4224.