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## DE DDS Comments Regarding Proposed Revised Digestive System Listings

1. The proposal to require "at least 6 months of observations and treatment" is puzzling. Although the proposal indicates that a fully favorable decision could be made without 6 months of evidence, the reality is that the proposed changes clearly indicate the DDS will be obtaining more information and holding cases for longer periods of time. Such a change will certainly result in a financial hardship to disabled persons waiting for disability decisions. Due to the advances in medical treatment and technology, we acknowledge that such treatment will, in many cases, result in improved functioning. However, the 12-month durational requirement has been a long-standing part of the definition of disability. We believe that many digestive cases can be fairly evaluated after 3 months of response to treatment and such medical judgment should be reserved to the adjudicative team.
2. We further acknowledge that due to advances in medical treatment and technology some of these claimants will respond and not be disabled for long periods of time. A better way to address this issue would be to fix the MIE diary process. It is our experience that some cases allowed with 1-year diaries fall through the cracks and are not reviewed for many years. If the CDRs on MIE cases were conducted when due the system could realize significant cost savings without undue hardship on behalf of the disabled public.
3. The revised listings calling for 6 months of treatment will likely result in more denials at the initial & recon level. More denials will result in more appeals. Since OHA/ALJ allowance rates are significantly higher than the DDS, more allowances at the ALJ level would be expected. If ALJs allowed them as not meeting the listings, the MIRS would result in continued disability payments thus significantly increasing program costs. If severely ill persons could meet the Digestive Listings with 3 months of evidence, the DDS could process these claims with MIE diaries (presuming they met the other MIE criteria) which would result in valid cessations for medical improvement thus resulting in significant cost savings.
4. The instructions regarding rounding of height could be clarified. POMS DI 24501.030 explains this issue and states that the height should be rounded off to give the advantage to the individual. The explanation in the revised Digestive Listings leads to the same result given rounding of half inches to the next higher inch. However, rounding of pounds is not addressed. If we follow the intent of the POMS (by giving the claimant the advantage), we should round half pounds down. Please clarify. ✓
5. The statement that, "anemia, when caused by inflammatory bowel disease, is not an appropriate indicator of listing-level severity" is perplexing. We have long held that chronic anemia with hematocrit persisting below 30 percent is listing level severity. (Refer to Listing 7.02A.) Is the move towards "functional" restrictions replacing long-held medical understanding that a person with chronic anemia is tired, fatigued, has poor stamina and other factors regarding their ability to "function?" If so, an individual with a hematocrit above 30, but non-medical evidence regarding their pain and fatigue would be allowed using the Process Unification (PU) standard. However, individuals with hematocrits below 30, but are too sick to return their pain

and ADL forms could be denied despite objective medical evidence of persistent anemia.

6. Proposed Listing 5.05B increases the documentation requirement for ascites from 5 months to 6 months, "to be consistent with other proposed digestive system listings." This seems arbitrary and unfair to the disabled public. Not all impairments fit neatly into six-month blocks. It is hard to understand that a listing would be changed simply to coincide with an arbitrary time frame without regard for long-held understanding of medical severity.
7. Concerning projected program and administrative costs, ref to items 2 & 3 above. Additionally, consideration should be given to the cost relative to increased DDS caseloads resulting from documenting longer treatment periods.