Materials on SSA's Policies for Evaluating Cases Involving Drug Addiction and Alcoholism ("DAA") and Failure to Follow Prescribed Treatment: SSR 13-2p and SSR 18-3p

SOAR Dialogue Phone Call

August 18, 2020

Brian P. Hogan
Supervising Attorney

Legal Aid of North Carolina, Inc.
122 N. Elm Street, Suite 700
Greensboro, NC
(336) 398-1705
brianh2@legalaidnc.org

Table of Contents

SSR 13-2p: Evaluating Cases Involving Drug Addiction and Alcoholism (DAA)

Sarah H. Bohr, Sarah Bohr's Pocket Guide to Key Social Security Rulings Tenth Edition (2019)

A. Topics Addressed

- Consolidates information from multiple sources to explain SSA policy regarding drug addiction and alcoholism ("DAA")
- Replaces SSR 82-60
- Addresses 15 specific topics in question/answer format
- Defines DAA
- Explains how the presence and materiality of DAA is determined
- Discusses various scenarios and complications that arise in these cases
- Outlines the findings decisions must contain

B. Overview of Ruling

This Ruling replaces SSR 82-60 and aims to provide a statement of current SSA policy regarding drug addiction and alcoholism ("DAA"), bringing together information from a variety of sources such as the Diagnostic and Statistical Manual of Mental Disorders ("DSM"), regulatory provisions, and the HALLEX. SSR 13-2p covers topics including how it is determined whether a claimant has DAA, when DAA is considered material, what evidence is needed, how periods of abstinence are considered, whether failure to follow treatment can be an issue, and what explanations the decision must contain.

C. Key Components

1. A claimant with disabling limitations is not considered disabled if drug addiction or alcoholism would be a

contributing factor material to the disability determination.

SSR 13-2p observes that pursuant to sections 223(d)(2)(c). and 1614(a)(3)(J) of the Social Security Act, a claimant cannot be considered disabled where alcoholism or drug addiction would be a contributing factor material to the determination of disability. Once it is found that the evidence from acceptable medical sources establishes DAA is a medically determinable impairment, it must be determined whether an otherwise disabled claimant would continue to experience disabling limitations if the use of drugs or alcohol ceased. If the disability would resolve, then DAA is "material" to the finding of disability. *See* 20 C.F.R. §§ 404.1535, 416.935.

2. SSR 13-2p defines DAA largely by reference to the DSM.

Apart from nicotine use disorders, which are not considered potentially material, SSA defines DAA as Substance Dependence or Substance Abuse in accordance with the latest edition of the DSM. Disorders induced by substance abuse are not considered, except for Substance-Induced Persisting Dementia and Substance-Induced Persisting Amnestic Disorder. The Ruling describes these latter disorders and the evidence required to document them.

DAA is diagnosed, in part, by the presence of maladaptive use of alcohol, illegal drugs, prescription medications, or toxic substances. DAA thus does not include: (1) fetal alcohol syndrome; (2) fetal cocaine exposure; or (3) addiction to, or use of, prescription medications taken as prescribed. The Ruling clarifies that occasional maladaptive use or a history of occasional prior maladaptive use does not establish a medically determinable Substance Use Disorder. A claimant has DAA only where s/he has a medically determinable Substance Use Disorder, which is decided using the same rules as for any other medically determinable impairment.

3. DAA is not material if the claimant would still be found disabled if the drug or alcohol use stopped.

The Ruling emphasizes that DAA is not material where the claimant would still be disabled in the absence of drug or alcohol use. Where a history of DAA exists that is not

relevant to the period under consideration, there is not even a need for a material determination. Similarly, where the claimant has a disabling impairment(s) unrelated to, and not exacerbated by DAA, or that is irreversible, DAA is not material and no further development of DAA evidence is appropriate.

4. The claimant bears the burden of proving disability throughout the DAA materiality analysis.

   SSA policy specifies that the claimant continues to bear the burden of proving disability where the steps of the sequential evaluation process must be applied a second time to determine the materiality of DAA. However, there need not be evidence from a period of abstinence for this burden to be met. Moreover, SSA must "find that DAA is not material to the determination of disability and allow the claim if the record is fully developed and the evidence (including medical opinion evidence) does not establish that the claimant's . . . impairment(s) would improve to the point of nondisability in the absence of DAA."

5. Where the claimant's other impairment(s) is not itself disabling, DAA is material.

   If, without regard to the interaction of DAA and the other impairment(s), it is determined the other impairment(s) does not produce disabling limitations, then DAA is necessarily material. However, the Ruling requires that in such situations adjudicators "must still apply the sequential evaluation twice, first to show that the claimant is disabled considering all MDIs, including DAA, and a second time to show that the claimant would not be disabled absent DAA."

6. Where the claimant's other impairment(s) might be disabling absent DAA, the materiality inquiry differs depending on the nature of the other impairment(s).

   The Ruling differentiates between physical impairments and mental impairments for the purpose of assessing materiality. Certain physical impairments are recognized as likely to improve with abstinence, such as alcoholic hepatitis, fatty liver, and alcoholic cardiomyopathy. In such cases, medical opinions about the likely effects of abstinence are relevant. Ordinarily, however, the best

evidence for determining the effect of abstaining is evidence from a relevant period of abstinence. Indeed, the Ruling cautions:

> Adjudicators should generally not rely on a medical opinion to find that DAA is material if the case record contains credible evidence from an acceptable medical source from a relevant period of abstinence indicating that the impairment(s) would still be disabling in the absence of DAA. In cases in which it is appropriate to rely on a medical opinion to find that DAA is material despite evidence indicating the impairment(s) may not improve, adjudicators must provide an appropriate rationale to resolve the apparent conflict in the evidence.

Further, DAA is not to be deemed material where the fully developed record fails to establish that abstinence would improve the claimant's physical impairment(s) to the point of nondisability.

Where the claimant has another impairment(s) that is mental in nature, the situation is different. SSR 13-2p concedes "[w]e do not know of any research data that we can use to predict reliably that any given claimant's co-occurring mental disorder would improve, or the extent to which it would improve, if the claimant were to stop using drugs or alcohol." Therefore, "[u]nlike cases involving physical impairments, we do not permit adjudicators to rely exclusively on medical expertise and the nature of a claimant's mental disorder." To support a finding that DAA is material in cases involving mental impairment(s), there must be other evidence in the case record establishing the claimant would not be disabled in the absence of DAA.

7. SSR 13-2p recognizes the importance of evidence from "other" sources.

The Ruling acknowledges that many claimants receive care from sources that are not acceptable medical sources, and that evidence from these sources can be helpful in determining the severity of DAA and whether DAA is material to the finding of disability. This information can describe a claimant's functioning over time and be especially helpful in documenting the severity of DAA and

can assist in the determination of materiality by documenting how the well the claimant performs daily living activities in the presence of a comorbid impairment. The Ruling recognizes that "[i]n many cases, evidence from 'other' sources may be the most important information in the case record for these documentation issues."

8. Improvement during a period of abstinence may not indicate materiality.

SSR 13-2p cautions that improvement of a co-occurring mental disorder that occurs "in a highly structured treatment setting, such as a hospital or substance abuse rehabilitation center, may be due at least in part to treatment for the co-occurring mental disorder, not (or not entirely) the cessation of substance use." The Ruling states:

> A co-occurring mental disorder may appear to improve because of the structure and support provided in a highly structured treatment setting. As for any mental disorder, we may find that a claimant's co-occurring mental disorder(s) is still disabling even if increased support or a highly structured setting reduce the overt symptoms and signs of the disorder.

Unless the evidence demonstrates "the separate effects of the treatment for DAA and for the co-occurring mental disorder(s), we will find that DAA is not material[.]" The Ruling concludes:

> Given the foregoing principles, a single hospitalization or other inpatient intervention is not sufficient to establish that DAA is material when there is evidence that a claimant has a disabling co-occurring mental disorder(s). We need evidence from outside of such highly structured treatment settings demonstrating that the claimant's co-occurring mental disorder(s) has improved, or would improve, with abstinence. In addition, a record of multiple hospitalizations, emergency department visits, or other treatment for the co-occurring mental disorder—with or without treatment for DAA—is an indication that DAA may not be material even if the claimant is discharged in improved condition after each intervention.

9. Adjudicators must provide a sufficient explanation for their findings in DAA cases.

   SSR 13-2p requires adjudicators to provide sufficient information that a subsequent reviewer considering the evidence of record can understand the reasons for: (1) the finding that the claimant has DAA; (2) the finding that the claimant is disabled at step 3 or step 5 of the sequential evaluation process considering all of his/her impairments, including DAA; and (3) the finding that the claimant would still be disabled at step 3 or 5 of the sequential evaluation process in the absence of DAA, or the finding that the claimant would not be disabled at step 2, 4, or 5 of the sequential evaluation process in the absence of DAA. This information must be provided by the ALJ, or by the Appeals Council (when the Appeals Council makes a decision), in the decision rationale.

Effective Date: March 22, 2013
Publication Date: February 20, 2013
Federal Register Vol. 78, No. 34, page 11939

POLICY INTERPRETATION RULING

SSR 13-2p: TITLES II AND XVI: EVALUATING CASES INVOLVING DRUG ADDICTION AND ALCOHOLISM (DAA)

This Social Security Ruling (SSR) rescinds and replaces SSR 82-60: "Titles II and XVI: Evaluation of Drug Addiction and Alcoholism."

PURPOSE: This SSR explains our policies for how we consider whether "drug addiction and alcoholism" (DAA) is a contributing factor material to our determination of disability in disability claims and continuing disability reviews.[1]

CITATIONS: Sections 216(i), 223(d), 223(f), 1614(a). and 1614(c) of the Social Security Act, as amended; Regulations No. 4, subpart P, sections 404.1502, 404.1505, 404.1508, 404.1509, 404.1512, 404.1513, 404.1517, 404.1519a, 404.1520, 404.1521, 404.1523, 404.1527, 404.1528, 404.1530, 404.1535, 404.1560, 404.1594, and appendix 1; and Regulations No. 16, subpart I, sections 416.902, 416.905, 416.906, 416.908, 416.909, 416.912, 416.913, 416.917, 416.919a, 416.920, 416.921, 416.923, 416.924, 416.924a, 416.926a, 416.927, 416.928, 416.930, 416.935, 416.960, 416.987, 416.994, and 416.994a.

INTRODUCTION: In this SSR, we consolidate information from a variety of sources to explain our DAA policy. We include information from our regulations, training materials, and question-and-answer (Q&A) responses. We also base the SSR on information we obtained from individual medical and legal experts, the Substance Abuse and Mental

Health Services Administration in the U.S. Department of Health and Human Services, and our adjudicative experience.

POLICY INTERPRETATION:

General

a. Sections 223(d)(2)(C) and 1614(a)(3)(J) of the Social Security Act (Act) provide that a claimant "shall not be considered to be disabled * * * if alcoholism or drug addiction would * * * be a contributing factor material to the Commissioner's determination that the individual is disabled." When we adjudicate a claim for disability insurance benefits (DIB), Supplemental Security Income (SSI) payments based on disability, or concurrent disability claims include evidence from acceptable medical sources as defined in 20 CFR 404.1513 and 20 CFR 416.913 establishing that DAA is a medically determinable impairment(s) (MDI) *and* we determine that a claimant is disabled considering all of the claimant's medically determinable impairments (MDIs), we must then determine whether the claimant would continue to be disabled if he or she stopped using drugs or alcohol; that is, we will determine whether DAA is *"material"* to the finding that the claimant is disabled. 20 CFR 404.1535 and 416.935. See Question 2 for additional information.

b. The information that follows, presented in question and answer (Q&A) format with illustrative scenarios, provides specific detail and examples to explain our DAA policy. Question 1 specifies the MDIs we consider under our DAA policy. Different Q&As will apply during the adjudication of a specific claim based upon the evidence in that case. All adjudicators must provide sufficient information in their determination or decision that explains the rationale supporting their determination of the materiality of DAA so that a subsequent reviewer considering all of the evidence in the case record is able to understand the basis for the materiality finding and the determination of whether the claimant is disabled. Question 14 specifies what information adjudicators must include in a determination or decision that requires a finding of the materiality of DAA to the determination that the claimant is disabled.

List of Questions

6. *What do we do if the claimant's other physical impairment(s) improve to the point of nondisability in the absence of DAA?*
7. *What do we do if the claimant's co-occurring mental disorder(s) improve in the absence of DAA?*
8. *What evidence do we need in cases involving DAA?*
9. *How do we consider periods of abstinence?*
10. *How do we evaluate a claimant's credibility in cases involving DAA?*
11. *How do we establish onset in DAA cases?*
12. *Can failure to follow prescribed treatment be an issue in DAA cases?*
13. *Who is responsible for determining materiality?*
14. *What explanations does the determination or decision need to contain?*
15. *How should adjudicators consider Federal district and circuit court decisions about DAA?*

1. How do we define the term "DAA"?

a. Although the terms "drug addiction" and "alcoholism" are medically outdated, we continue to use the terms because they are used in the Act.[2]

i. With one exception—nicotine use disorders—we define the term *DAA* as *Substance Use Disorders*; that is, *Substance Dependence* or *Substance Abuse* as defined in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association.[3] See Question 4. In general, the DSM defines *Substance Use Disorders* as maladaptive patterns of substance use that lead to clinically significant impairment or distress.[4]

ii. There are two Substance-Induced Disorders that we consider under the definition of DAA because they may be long lasting or permanent. Substance-Induced Persisting Dementia and Substance-Induced Persisting Amnestic Disorder last beyond the usual duration of substance intoxication and withdrawal. Substance-Induced Persisting Dementia refers to the development of multiple cognitive deficits that include memory impairment and at least one of the following cognitive disturbances: aphasia, apraxia, agnosia, or a disturbance in executive functioning. To document this condition, there must be evidence from the medical history, physical examination, or laboratory findings showing that the deficits are due to the persisting effects of substance use.

Substance-Induced Persisting Amnestic Disorder refers to a combination of multiple memory deficits that significantly impair social or occupational functioning and represent a significant decline from a previous level of functioning. To document this condition, the evidence must establish that the deficits are clearly due to the persisting effects of substance abuse.

b. *Substance Use Disorders* are diagnosed in part by the presence of maladaptive use of alcohol, illegal drugs, prescription medications, and toxic substances (such as inhalants)[5]. For this reason, *DAA* does not include:

- Fetal alcohol syndrome,
- Fetal cocaine exposure, or
- Addiction to, or use of, prescription medications taken as prescribed, including methadone and narcotic pain medications.

A claimant's occasional maladaptive use or a history of occasional prior maladaptive use of alcohol or illegal drugs does not establish that the claimant has a medically determinable *Substance Use Disorder*. See Questions 4 and 8.

c. Although the DSM includes a category for nicotine-related disorders, including nicotine dependence, we will not make a determination regarding materiality based on these disorders.[6]

2. What is our DAA policy?

The key factor we will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether we would still find a claimant disabled if he or she stopped using drugs or alcohol.

a. *DAA* is not *material* to the determination that the claimant is under a disability if the claimant *would still meet our definition of disability*[7] if he or she were not using drugs or alcohol. If *DAA* is not *material*, we find that the claimant is disabled.[8]

b. *DAA* is *material* to the determination of disability if the claimant *would not meet our definition of disability* if he or she were not using drugs or alcohol. If *DAA* is *material*, we find that the claimant is not disabled.

3. When do we make a DAA materiality determination?

a. Under the Act and our regulations, we make a *DAA materiality* determination only when:

i. We have medical evidence from an acceptable medical source establishing that a claimant has a *Substance Use Disorder*, and

ii. We find that the claimant is disabled considering all impairments, including the *DAA*.[9]

b. We do not make a determination regarding *materiality* if a claimant has a history of *DAA* that is not relevant to the period under consideration.

4. How do we determine whether a claimant has DAA?

Subject to the exception regarding nicotine use disorders in Question 1 above, a claimant has DAA only if he or she has a medically determinable *Substance Use Disorder*. The DSM includes all medically determinable *Substance Use Disorders*; therefore, we do not require adjudicators to identify a specific DAA diagnosis in the DSM. We use the same rules for determining whether a claimant has a *Substance Use Disorder* as we use for any other medically determinable physical or mental impairment. See Question 8.

5. How do we determine materiality?

a. *Burden of Proof*. The claimant has the burden of proving disability throughout the sequential evaluation process. Our only burden is limited to producing evidence that work the claimant can do exists in the national economy at step 5 of the sequential evaluation process. See 20 CFR 404.1512, 404.1560, 416.912, and 416.960. When we apply the steps of the sequential evaluation a second time to determine whether the claimant would be disabled if he or she were not using drugs or alcohol, it is our longstanding policy that the claimant continues to have the burden of proving disability throughout the DAA materiality analysis. There does not have to be evidence from a period of abstinence for the claimant to meet his or her burden of proving disability. See Question 9, section (d) (i). b. *DAA Evaluation Process*. We describe various considerations that may apply when we decide whether we must consider the issue of *materiality* and, if so, whether *DAA* is material to the determination of disability. In this SSR, we address these considerations as a "*DAA* evaluation process" in a series of six steps. Although the steps are in a logical order from the simplest to the most complex cases, we do not require our adjudicators to follow them in the order we provide. For example, when DAA is the only impairment adjudicators can go directly to step three and deny the claim because DAA is material.

In the sections that follow, we provide more details about the DAA Evaluation Process.

1. Does the claimant have *DAA*?	a. No–No *DAA* materiality determination necessary. b. Yes–Go to step 2.
2. Is the claimant disabled considering all impairments, including *DAA*?	a. No–Do not determine *DAA* materiality. (Denial.) b. Yes–Go to step 3.
3. Is *DAA* the only impairment?	a. Yes–*DAA* material. (Denial.) b. No–Go to step 4.
4. Is the other impairment(s) disabling by itself while the claimant is dependent upon or abusing drugs or alcohol?	a. No–*DAA* material. (Denial.) b. Yes–Go to step 5.
5. Does the *DAA* cause or affect the claimant's medically determinable impairment(s)?	a. No–*DAA* not material. (Allowance.) b. Yes, but the other impairment(s) is irreversible or could not improve to the point of nondisability–*DAA* not material. (Allowance.) c. Yes, and *DAA* could be material–Go to step 6.
6. Would the other impairment(s) improve to the point of nondisability in the absence of *DAA*?	a. Yes–*DAA* material. (Denial.) b. No–*DAA* not material (Allowance.)

The following are detailed explanations of each step.

a. *Step 1: Does the claimant have DAA?* If the evidence does not establish *DAA*, there can be no issue of *DAA* materiality. See Questions 3 and 8. Apply the appropriate sequential evaluation process only once to determine whether the claimant is disabled.

b. *Step 2: Is the claimant disabled considering all of his or her impairments, including DAA?* Apply the appropriate sequential evaluation process to determine whether the claimant is disabled considering all of his or her impairments, including *DAA*.[10] If the claimant is not disabled, deny the claim.[11]

c. *Step 3: Is DAA the claimant's only impairment?* Find that DAA is material to the determination of disability and deny the claim if the

claimant's only MDI is a *Substance Use Disorder*.[12] As in all *DAA* materiality determinations, apply the appropriate sequential evaluation process twice. First, apply the sequential evaluation process to show how the claimant is disabled. Then, apply the sequential evaluation process a second time to document materiality and deny the claim.[13]

d. *Step 4: Is the claimant's other MDI(s) disabling by itself while the claimant is dependent upon or abusing drugs or alcohol?*

i. A second application of the sequential evaluation process may demonstrate that the claimant's other physical or mental impairment(s) is not sufficiently severe to establish disability by itself while the claimant is dependent upon or abusing drugs or alcohol. In this case, deny the claim because *DAA* is material. The claimant would not be disabled regardless of whether the other impairment(s) would improve if he or she stopped using the substance(s) he or she is dependent upon or abusing. For example:

- The other impairment(s) may not be severe while the claimant is still dependent upon or abusing the substance(s).[14] For example, if a claimant has osteoarthritis of the hip with minimal changes on imaging along with *DAA*, *DAA* is generally material to the determination of disability. We would generally deny the claimant at step 2 of the sequential evaluation process based on osteoarthritis of the hip with minimal changes on imaging alone, regardless of whether the osteoarthritis would improve absent the *DAA*, because it would not significantly limit the claimant's ability to do basic work activities.[15]
- The other impairment(s) may be severe but not disabling by itself. For example, a claimant may have a severe back impairment that does not meet or medically equal a listing and does not preclude a claimant from doing past relevant work. We would deny the claim at step 4 of the sequential evaluation process based on the back impairment alone because *DAA* is material.

ii. When the claimant's other impairment(s) is not disabling by itself, adjudicators must still apply the sequential evaluation twice, first to show that the claimant is disabled considering all MDIs, including *DAA*, and a second time to show that the claimant would not be disabled absent *DAA*. However, we do not require adjudicators to determine whether the other impairment would improve if the claimant stopped using drugs or alcohol he or she is dependent upon or abusing because DAA materiality is established without this additional analysis.

e. *Step 5: Does the DAA cause or affect the claimant's other MDI(s)?*

i. If the claimant has another physical or mental impairment(s) that results in disability[16] and *DAA* is not causing or does not affect the other impairment(s) to the point where the other impairment(s) could be found nondisabling in the absence of *DAA*, *DAA* is not material to the determination of disability. The claim should be allowed. There are three basic scenarios:

- The claimant has a disabling impairment independent of DAA; for example, a degenerative neurological disease, a hereditary kidney disease that requires chronic dialysis, or intellectual disability (mental retardation) since birth. See 20 CFR 404.1535(b)(2)(ii) and 416.935(b)(2)(ii).
- The claimant *acquired a separate disabling impairment(s) while using* a substance(s). One example is the claimant has quadriplegia because of an accident while driving under the influence of alcohol. A second example is the claimant acquired listing-level human immunodeficiency virus (HIV) infection from sharing a needle for intravenous drug use. In each example, the claimant acquired the impairment because of an activity related to substance use, but the *Substance Use Disorder* did not medically cause or exacerbate the impairment.
- The claimant's *DAA medically caused* the other disabling impairment(s) *but the other impairment(s) is irreversible or could not improve to the point of nondisability* in the absence of *DAA*. Examples of such impairments could include peripheral neuropathy, permanent encephalopathy, cirrhosis of the liver, Substance-Induced Persisting Dementia, and Substance-Induced Persisting Amnestic Disorder that result from long-term alcohol or drug use.

ii. As in any determination regarding materiality, adjudicators must apply the sequential evaluation process twice even when the other impairment(s) is irreversible or could not improve to the point of nondisability.

f. *Step 6: Would the claimant's other impairment(s) improve to the point of nondisability in the absence of DAA?*

i. This step includes some of the most complex cases for the *DAA materiality* analysis. At this point, we have determined that:

- The claimant has DAA and at least one other medically determinable physical or mental impairment,

- The other impairment(s) could be disabling by itself, and
- The other impairment(s) might improve to the point of nondisability if the claimant were to stop using drugs or alcohol.

ii. At this step, we must project the severity of the claimant's other impairment(s) in the absence of *DAA*. We make this finding based on the evidence in the claimant's case record. In some cases, we may also consider medical judgments about the likely remaining medical findings and functional limitations the claimant would have in the absence of *DAA*. How we make this finding differs somewhat depending on whether the claimant's other impairment(s) is physical or mental. See Questions 6 and 7, respectively.

iii. *DAA* is material if the claimant's other impairment(s) would improve to the point that the claimant would not be disabled in the absence of *DAA*. On these findings, we deny the claim. However, if the claimant's other impairment(s) would not improve to the point that the claimant would not be disabled in the absence of *DAA*, we allow the claim. In this instance, the DAA is not material to the determination of disability.

6. What do we do if the claimant's other physical impairment(s) improve in the absence of DAA?

a. *DAA* can cause or exacerbate the effects of physical impairments. In some cases, the impairments and their effects may resolve or improve in the absence of *DAA*.

b. Usually, evidence from a period of abstinence[17] is the best evidence for determining whether a physical impairment(s) would improve to the point of nondisability. The period of abstinence should be relevant to the period we are considering in connection with the disability claim.[18] This evidence need not always come from an acceptable medical source. If we are evaluating whether a claimant's work-related functioning would improve, we may rely on evidence from "other" medical sources, such as nurse practitioners, and other sources, such as family members, who are familiar with how the claimant has functioned during a period of abstinence. See Question 8.

c. We expect some physical impairments to improve with abstinence from drugs or alcohol.

i. Examples of such impairments that drugs or alcohol may cause or exacerbate include alcoholic hepatitis, fatty liver, and alcoholic cardiomyopathy.

ii. When a claimant has a physical impairment(s) that is likely to improve with abstinence, we may consider medical opinions from treating or nontreating sources about the likely effects that abstinence from drugs or alcohol would have on the impairment(s).[19] Treating sources, especially specialists, may have the best understanding of the specific clinical course of a claimant's *DAA* and other impairment(s), as well as whether, and the extent to which the other impairment(s) would likely improve absent *DAA*. If the treating source does not give supporting evidence for his or her opinion, the adjudicator should consider contacting the treating source before considering purchasing a consultative exam (CE). If we purchase a CE to evaluate the physical impairment(s), we may ask the CE provider for an opinion about whether and the extent to which the impairment(s) would be expected to improve. We will not purchase a CE solely to obtain such an opinion. In any case, we will not adopt a medical opinion about whether the impairment(s) would improve unless the medical source provides some support for the opinion. The opinion may be supported by the medical source's knowledge and expertise.

iii. At the State agency levels of the administrative review process, a State agency medical or psychological consultant (MC/PC) may use his or her knowledge and expertise to project improvement of a physical impairment(s). At the hearing and appeals levels, Administrative Law Judges (ALJs) and the Appeals Council (when the Appeals Council makes a decision) must consider such MC/PC findings as medical opinion evidence and may base their findings about *materiality* on these opinions. ALJs and the Appeals Council may also base their findings on testimony from medical experts. As we provide in our regulations on considering nonexamining source opinion evidence, ALJs and the Appeals Council will give weight to these opinions to the extent that they are supported and consistent with other relevant evidence in the case record.[20] Medical source knowledge and expertise are factors that may support the finding.

iv. Some claimants who have been diagnosed with a Substance Use Disorder do not have a period of abstinence. If a claimant does not have a period of abstinence, an acceptable medical source can provide a medical opinion regarding whether the claimant's impairments would be severely limiting even if the claimant stopped abusing drugs or alcohol. We consider the opinion of an acceptable medical source sufficient evidence regarding materiality as long as the acceptable medical source

provides support for their opinion. The determination or decision must include information supporting the finding. See Question 14.

v. Adjudicators should generally not rely on a medical opinion to find that *DAA* is *material* if the case record contains credible evidence from an acceptable medical source from a relevant period of abstinence indicating that the impairment(s) would still be disabling in the absence of *DAA*. In cases in which it is appropriate to rely on a medical opinion to find that *DAA* is material despite evidence indicating the impairment(s) may not improve, adjudicators must provide an appropriate rationale to resolve the apparent conflict in the evidence.

d. We will find that *DAA* is not material to the determination of disability and allow the claim if the record is fully developed and the evidence (including medical opinion evidence) does not establish that the claimant's physical impairment(s) would improve to the point of nondisability in the absence of *DAA*.

7. What do we do if the claimant's co-occurring mental disorder(s) improve in the absence of DAA?

a. Many people with *DAA* have co-occurring mental disorders; that is, a mental disorder(s) diagnosed by an acceptable medical source in addition to their *DAA*. We do not know of any research data that we can use to predict reliably that any given claimant's co-occurring mental disorder would improve, or the extent to which it would improve, if the claimant were to stop using drugs or alcohol.

b. To support a finding that *DAA* is material, we must have evidence in the case record that establishes that a claimant with a co-occurring mental disorder(s) would not be disabled in the absence of *DAA*. Unlike cases involving physical impairments, we do not permit adjudicators to rely exclusively on medical expertise and the nature of a claimant's mental disorder.

c. We may purchase a CE in a case involving a co-occurring mental disorder(s). We will purchase CEs primarily to help establish whether a claimant who has no treating source records has a mental disorder(s) in addition to *DAA*. See Question 8. We will provide a copy of this evidence, or a summary, to the CE provider.

d. We will find that *DAA* is not material to the determination of disability and allow the claim if the record is fully developed and the evidence does not establish that the claimant's co-occurring mental disorder(s) would improve to the point of nondisability in the absence of *DAA*.

8. What evidence do we need in cases involving DAA?

a. General.

We follow our usual case development rules and procedures for any impairment in cases in which *DAA materiality* is, or may be, an issue.[21] We will ask for evidence regarding DAA in any case in which there is an allegation or other indication that the claimant has a *Substance Use Disorder*, such as evidence that a claimant is currently receiving treatment for a *Substance Use Disorder* or evidence of multiple emergency department admissions due to the effects of substance(s) use. If we do not initially receive sufficient evidence to evaluate *DAA*, we may or may not continue to develop evidence of *DAA*, as follows:

i. We will not continue to develop evidence of *DAA* if the evidence we obtain about a claimant's other impairment(s) is complete and shows that the claimant is *not disabled*. We will not complete development of *DAA* only to determine whether the claimant is disabled considering *DAA* because the additional evidence could only change the reason for our denial.

ii. We will not continue to develop evidence of *DAA* if the claimant is disabled by another impairment(s) and *DAA could not be material* to the determination of disability. For example, if the claimant has a disabling impairment(s) that is unrelated to, and not exacerbated by *DAA*, or that is irreversible, we would find that *DAA* is not material to the determination of disability even if we completed the development.

iii. We will attempt to complete development of *DAA* in all other cases, including cases in which *DAA* is a claimant's only alleged impairment. We generally require our adjudicators to make every reasonable effort to develop a complete medical history. Moreover, many claimants with *DAA* have other physical and mental impairments, and complete development ensures that we do not overlook any impairments.

b. *Establishing the existence of DAA.*

i. As for any medically determinable impairment, we must have objective medical evidence—that is, signs, symptoms, and laboratory findings—from an acceptable medical source that supports a finding that a claimant has *DAA*.[22] This requirement can be satisfied when there are no overt physical signs or laboratory findings with clinical findings reported by a psychiatrist, psychologist, or other appropriate acceptable medical source based on examination of the claimant. The acceptable medical source may also consider any records or other information (for

example, from a third party) he or she has available, but we must still have the source's own clinical or laboratory findings.

ii. Evidence that shows only that the claimant uses drugs or alcohol does not in itself establish the existence of a medically determinable Substance Use Disorder. The following are examples of evidence that by itself does not establish *DAA*:

- Self-reported drug or alcohol use.
- An arrest for "driving under the influence".
- A third-party report.

Although these examples may suggest that a claimant has *DAA*—and may suggest the need to develop medical evidence about *DAA*—they are not objective medical evidence provided by an acceptable medical source. In addition, even when we have objective medical evidence, we must also have evidence that establishes a maladaptive pattern of substance use and the other requirements for diagnosis of a Substance Use Disorder(s) in the DSM. This evidence must come from an acceptable medical source.

c. *Other evidence.*

i. Many claimants with *Substance Use Disorders* receive care from "other" non-medical and medical sources that are not acceptable medical sources. Evidence from these sources can be helpful to the adjudicator in determining the severity of DAA and whether DAA is material to the finding of disability.[23] Examples of "other" nonmedical sources include, but are not limited to: Non-clinical social workers, caseworkers, vocational rehabilitation specialists, family members, school personnel, clergy, friends, licensed chemical dependency practitioners, and the claimant. Examples of "other" medical sources include but are not limited to: nurse practitioners, physicians' assistants and therapists.

ii. When we have information from "other" sources, we may consider it together with objective medical findings from a treating or nontreating acceptable medical source to document that a claimant has *DAA*. Information from "other" sources can describe a claimant's functioning over time and can also be especially helpful in documenting the severity of *DAA because it supplements the medical evidence of record*. "Other" source opinions can assist in our determination whether *DAA* is material to a finding of disability because it can document how the well the claimant is performing activities of daily living in the presence of a comorbid impairment. In many cases, evidence from "other" sources

may be the most important information in the case record for these documentation issues.[24]

d. *Consultative examinations.*

i. We may purchase a CE if there is no existing medical evidence or the evidence as a whole, both medical and nonmedical, is insufficient for us to make a determination or decision. The type and number of CEs we purchase will depend on the claimant's allegations and the other information in the case record. For instance, claimants who have a history of multiple emergency department visits for mental symptoms are often diagnosed with Substance-Induced Disorders. Some receive a Substance Dependence or Substance Abuse diagnosis. Many of these individuals—especially those who do not have an ongoing treatment relationship with a medical source, as is frequently the case with homeless claimants—may have undiagnosed co-occurring mental disorders. We may purchase CEs to help us determine whether such claimants have co-occurring mental disorder(s). Whenever possible, we will try to purchase CEs from individuals who specialize in treating and examining people who have *Substance Use Disorders* or dual diagnoses of *Substance Use Disorders* and co-occurring mental disorders. See Questions 6 and 7 for more specific information about purchasing CEs for physical and mental impairments.

ii. We will not purchase drug or alcohol testing. A single drug or alcohol test is not sufficient to establish *DAA* as a medically determinable impairment, nor does it provide pertinent information that can help us determine whether *DAA* is material to a finding of disability.[25]

9. How do we consider periods of abstinence?

a. Each substance of abuse, including alcohol, has different intoxication and long-term physiologic effects. In addition, there is a wide variation in the duration and intensity of substance use among claimants with *DAA*, and there are wide variations in the interactions of *DAA* with different types of physical and mental disorders. For these reasons, we are unable to provide exact guidance on the length and number of periods of abstinence to demonstrate whether *DAA* is material in every case. In some cases, the acute and toxic effects of substance use or abuse may subside in a matter of weeks, while in others it may take months or even longer to subside. For some claimants, we will be able to make a judgment about *materiality* based on evidence from a single, continuous period of abstinence, while in others we may need to consider more than one period.[26]

b. In all cases in which we must consider periods of abstinence, the claimant should be abstinent long enough to allow the acute effects of drug or alcohol use to abate. Especially in cases involving co-occurring mental disorders, the documentation of a period of abstinence should provide information about what, if any, medical findings and impairment-related limitations remained after the acute effects of drug and alcohol use abated. Adjudicators may draw inferences from such information based on the length of the period(s), how recently the period(s) occurred, and whether the severity of the co-occurring impairment(s) increased after the period(s) of abstinence ended. To find that *DAA* is *material*, we must have evidence in the case record demonstrating that any remaining limitations were not disabling during the period.[27]

In the sections that follow, we provide more detail about these general principles.

c. In addition to the length of the period, we must consider when the period of abstinence occurred.

d. We may also consider the circumstances under which a period(s) of abstinence takes place, especially in the case of a claimant with a co-occurring mental disorder(s).

i. Improvement in a co-occurring mental disorder in a highly structured treatment setting, such as a hospital or substance abuse rehabilitation center, may be due at least in part to treatment for the co-occurring mental disorder, not (or not entirely) the cessation of substance use. We may find that *DAA* is not material depending on the extent to which the treatment for the co-occurring mental disorder improves the claimant's signs and symptoms. If the evidence in the case record does not demonstrate the separate effects of the treatment for *DAA* and for the co-occurring mental disorder(s), we will find that *DAA* is not material, as we explain in Question 7.[28]

ii. A co-occurring mental disorder may appear to improve because of the structure and support provided in a highly structured treatment setting. As for any mental disorder, we may find that a claimant's co-occurring mental disorder(s) is still disabling even if increased support or a highly structured setting reduce the overt symptoms and signs of the disorder.[29]

iii. Given the foregoing principles, a single hospitalization or other inpatient intervention is not sufficient to establish that *DAA* is material when there is evidence that a claimant has a disabling co-occurring mental disorder(s). We need evidence from outside of such highly structured treatment settings demonstrating that the claimant's co-

occurring mental disorder(s) has improved, or would improve, with abstinence.[30] In addition, a record of multiple hospitalizations, emergency department visits, or other treatment for the co-occurring mental disorder—with or without treatment for *DAA*—is an indication that *DAA* may not be material even if the claimant is discharged in improved condition after each intervention.

10. How do we evaluate a claimant's credibility in cases involving DAA?

We do not have special rules for evaluating a claimant's credibility in cases involving *DAA*. Adjudicators must not presume that all claimants with *DAA* are inherently less credible than other claimants. We will apply our policy in SSR 96-7p and our regulations as in any other case, considering the facts of each case. In addition, adjudicators must consider a claimant's co-occurring mental disorder(s) when they evaluate the credibility of the claimant's allegations.

11. How do we establish onset in DAA cases?

We do not have special rules for establishing onset in *DAA* cases. In general, disability onset is the earliest date on which the evidence shows that the claimant became disabled due to a medically determinable impairment and that *DAA* was not material.

12. Can failure to follow prescribed treatment be an issue in DAA cases?

Yes, but it will rarely be necessary to consider the issue, and we will apply the policy only to a claimant's other physical or mental impairment(s), not the *DAA*.

a. The requirement to determine *DAA materiality* is similar to our policy on failure to follow prescribed treatment. Like that policy, it considers whether a claimant would be disabled if *DAA* improved. However, the claimant does not need to have been prescribed treatment for the *DAA* or to follow it.[31] Therefore:

- When we find that *DAA* is material to our determination of disability, we do not consider whether a treating source has prescribed treatment for the *DAA* that is clearly expected to restore the claimant's ability to work. We have already determined that the claimant *is not* disabled because DAA is material, and we consider the issue of failure to follow prescribed treatment only when we find that a claimant *is* disabled.
- A finding that *DAA is not* material also implies that there is no treatment for the *DAA* that is "clearly expected" to restore the

claimant's ability to work since the claimant would still be disabled in the absence of *DAA*. Moreover, we know of no treatments for *DAA* that are so sufficiently and uniformly effective that they could satisfy our requirement that the prescribed treatment be clearly expected to restore the ability to work.

b. There are cases in which we can deny a claim for failure to follow prescribed treatment for an impairment(s) *other than* the *DAA*. In a case in which a claimant has both *DAA* and at least one other impairment, we may determine that:

- *DAA* is not material to our determination of disability; that is the claimant would still be disabled in the absence of DAA, but
- The claimant would not be disabled by his or her *other* impairment(s) if he or she followed treatment prescribed by a treating source for that impairment(s) that is clearly expected to restore the ability to work. The claimant must also not have good cause for failing to follow the treatment.

The prescribed treatment in this case must be treatment that is specifically for the other impairment(s), not for the *DAA*, even if the treatment might also have beneficial effects on the *DAA*. For example, we cannot find that a claimant has failed to follow prescribed treatment for liver disease based on a failure to follow treatment prescribed for alcohol dependence. If the cessation of drinking would clearly be expected to improve the claimant's functioning to the point that he or she is not disabled, we would find that *DAA* is material to the determination of disability and deny the claim for that reason.

13. Who is responsible for determining materiality?

The following adjudicators are responsible for determining materiality:

a. At the initial and reconsideration levels of the administrative review process (except in disability hearings), a State agency disability examiner makes the finding whether *DAA* is material to the determination of disability. A State agency MC/PC is responsible for determining the medical aspects of the *DAA* analysis, such as what limitations a claimant would have in the absence of *DAA*.

b. In disability hearings conducted by a disability hearing officer at the reconsideration level, the disability hearing officer determines whether *DAA* is material to the determination of disability.

c. At the ALJ and Appeals Council levels (when the Appeals Council makes a decision), the ALJ or Appeals Council determines whether *DAA*

is material to the determination of disability.

14. What explanations does the determination or decision need to contain?

a. Adjudicators must provide sufficient information so that a subsequent reviewer considering all of the evidence in the case record can understand the reasons for the following findings whenever *DAA* materiality is an issue:

- The finding that the claimant has *DAA*;
- The finding that the claimant is disabled at step 3 or step 5 of the sequential evaluation process considering all of his or her impairments, including *DAA*.
- The finding that the claimant would still be disabled at step 3 or 5 of the sequential evaluation process in the absence of DAA, or the finding that the claimant would not be disabled at step 2, 4, or 5 of the sequential evaluation process in the absence of *DAA*.

A single statement that *DAA* is or is not material to the determination of disability by an adjudicator is not sufficient.

b. As we have already indicated in answering other questions, an adjudicator is not always required to address every issue related to materiality in detail. For example, an adjudicator need not determine what a claimant's remaining limitations would be absent DAA if the claimant's other impairment(s) does not prevent the claimant from doing past relevant work even with DAA. See Question 5.

c. Disability hearing officers, ALJs, and the Appeals Council (when the Appeals Council makes a decision) must provide their rationales in their determinations and decisions. State agency adjudicators may provide explanations in their determinations or on other appropriate documents, such as residual functional capacity assessment forms.

15. How should adjudicators consider Federal district and circuit court decisions about DAA?

Our policies for considering Federal court decisions are set out in SSR 96-1p and 20 CFR 404.1585 and 416.985.

a. General. We require adjudicators at all levels of administrative review to follow agency policy, as set out in the Commissioner's regulations, SSRs, Social Security Acquiescence Rulings (ARs), and other instructions, such as the Program Operations Manual System (POMS), Emergency Messages, and the Hearings, Appeals and Litigation Law manual (HALLEX). Under sections 205(a) and (b) and 1631(c) and (d) of

the Act, the Commissioner has the power and authority to make rules and regulations and to establish procedures, not inconsistent with the Act, which are necessary or appropriate to carry out the provisions of the Act. The Commissioner also has the power and authority to make findings of fact and decisions as to the rights of any individual applying for payment under the Act. Because of the Commissioner's delegated authority to implement the provisions of the Act, we may, from time to time, issue instructions that explain the agency's policies, regulations, rules, or procedures. All adjudicators must follow our instructions.

b. *District court decisions*. Under our longstanding policy, when a district court decision conflicts with our interpretation of the Act or our regulations, adjudicators must apply our nationwide policy when they adjudicate other claims within that district court's jurisdiction unless the court directs otherwise, such as in a class action.[32]

c. *Circuit courts*. If we determine that a circuit court's holding conflicts with our interpretation of the Act or our regulations, we will issue an AR explaining the court's holding, how it differs from our national policy, how adjudicators must apply the holding, and the situations in which the AR applies. Unless and until we issue an AR, adjudicators must follow our nationwide policy in adjudicating other claims within the circuit court's jurisdiction.

DATES: *Effective Date:* This SSR is effective on March 22, 2013.

CROSS REFERENCES: SSR 82-59, "Titles II and XVI: Failure To Follow Prescribed Treatment"; SSR 85-28, "Titles II and XVI: Medical Impairments That Are Not Severe"; SSR 96-1p, Application by the Social Security Administration (SSA) of Federal Circuit Court and District Court Decisions; SSR 96-4p, Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations; 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; SSR 96-7p, "Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements"; SSR 06-3p: 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; and Program Operations Manual System (POMS) DI 23010.005, DI

[1] For simplicity, we refer in this SSR only to initial adult claims for disability benefits under titles II and XVI of the Social Security Act, and to the steps of the sequential evaluation process we use to determine disability in those claims. 20 CFR 404.1520 and 416.920. The policy interpretations in this SSR apply to all other cases in which we must make determinations about disability, including claims of children (that is, people who have not attained age 18) who apply for benefits based on disability under title XVI of the Act, redeterminations of the disability of children who were receiving benefits under title XVI when they attained age 18, and continuing disability reviews of adults and children under titles II and XVI of the Act. 20 CFR 404.1594, 416.924, 416.987, 416.994, and 416.994a.

[2] See sections 223(d)(2)(C) and 1614(a)(3)(J) of the Act.

[3] American Psychiatric Association (APA), *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, (DSM-IV-TR)*, Washington, D.C. (2000). When we published this SSR, the APA used the term "dependence." The APA was considering changing the term "dependence" to "addiction" in the forthcoming DSM-V. For this SSR, there is no substantive difference between the two terms.

[4] See DSM-IV-TR p. 197, Criteria for Substance Dependence and p. 199 for Substance Abuse.

[5] We do not consider Caffeine–Induced Disorders under *DAA*. "Some individuals who drink large amounts of coffee display some aspects of dependence on caffeine and exhibit tolerance and perhaps withdrawal. However, the data are insufficient at this time to determine whether these symptoms are associated with clinically significant impairment that meets the criteria for Substance Dependence or Substance Abuse." *DSM-IV-TR* p. 231. Thus, it is not appropriate to make a determination of materiality because a claimant drinks coffee to excess and may have been diagnosed with a Caffeine-Induced Disorder. The DSM-IV-TR does not include diagnoses for Caffeine Dependence or Caffeine Abuse.

[6] We have further considered our policy in this area and have found no indication in the statutory language or the legislative history of the DAA provisions of the Act that Congress intended the DAA provisions to apply to people who use tobacco products.

[7] See Section 223(d)(1) of the Act.

[8] 20 CFR 404.1535 and 416.935.

[9] Under title XVI, "blindness" is a separate category from "disability," and section 1614(a)(3)(J) of the Act applies only to determinations of disability. For this reason, we do not consider the issue of *materiality* in cases of claimants with blindness under title XVI. 20 CFR 416.935(a).

[10] 20 CFR 404.1520 and 416.920.

[11] For all initial claims under title II and claims of adults under title XVI, this means that the impairment(s) must prevent the claimant from doing any substantial gainful activity and meet the duration requirement; that is, the impairment(s) must be expected to result in death or must have lasted or be expected to last for a continuous period of at least 12 months.

[12] Adjudicators should be cautious when making this finding because there is a high prevalence of physical and co-occurring mental impairments associated with long-term drug and alcohol use. If there is any indication in the record that the claimant has another physical or mental impairment(s), it is essential to request evidence regarding the other impairment(s). If there is no evidence of another physical or mental impairment(s), however, we will not develop for the mere possibility that the claimant might have another impairment(s).

[13] We consider two issues at step 2: whether the claimant has a medically determinable impairment and whether any medical determinable impairment the claimant has is "severe" and meets the duration requirement. *See* 20 CFR 404.1520(a)(4)(ii) and 416.920(a)(4)(ii); SSR 96-4p.

[14] *See* 20 CFR 404.1520(c), 404.1521, 416.920(c), and 416.921; SSR 85-28.

[15] In some cases, people use drugs or alcohol to lessen the symptoms of their other impairment(s). Adjudicators should be alert to any evidence in the case record that suggests that a claimant's symptoms may worsen in the absence of drugs or alcohol at this or any other step in this section. We do not require adjudicators to seek evidence of this possibility, but adjudicators should follow up when there is an indication in the case record that the claimant's symptoms worsen in the absence of substance use.

[16] Inherent in this finding is that the other impairment(s) meets the duration requirement in addition to preventing the claimant from working.

[17] In this SSR, we use the term *period of abstinence* to describe a period in which a claimant who has, or had, been dependent upon or abusing drugs or alcohol and stopped their use.

[18] The period of abstinence does not have to occur during the period we are considering in connection with the claim as long as it is medically relevant to the period we are considering. For example, a claimant for title XVI payments has a permanent physical impairment(s) that in some people improves when they stop abusing alcohol. However, there is evidence from a year before the date of the application showing that when this claimant stopped drinking, the impairment(s) improved only minimally. In this case, we may conclude that the impairment(s) would not improve to the point of nondisability in the absence of DAA. See also Question 9.

[19] The finding about materiality is an opinion on an issue reserved to the Commissioner under 20 CFR 404.1527(e) and 416.927(e). Therefore, we will not ask a treating source, a CE provider, a medical expert, or any other source for an opinion about whether DAA is material. We will instead ask for medical opinions about the nature, severity, and functional effects of a claimant's impairment(s). In cases involving physical impairments, we may ask for medical opinions that project the nature, severity, and functional effects if the claimant were to stop using drugs or alcohol. In cases involving mental impairment(s) we will not ask for projections, as we explain in Question 7.

[20] See 20 CFR 404.1527(f) and 416.927(f); SSR 96-6p.

[21] See 20 CFR 404.1512, 404.1513, 416.912, and 416.913.

[22] *See* 20 CFR 404.1502, 404.1508, 404.1513(a), and 404.928, and 20 CFR 416.902, 416.908, 416.913(a), and 416.928.

[23] 20 CFR 404 1513(d)(1) and 416.913d(1) and 20 CFR 1513(d)(4) and 416.913(d)(4).

[24] See SSR 06-3p.

[25] We will not purchase drug screening or testing to determine the validity of psychological testing. The examining psychologist or other professional who performs the test should be able to provide an opinion on the validity of the psychological test findings without drug testing.

[26] If, however, a claimant is abstinent and remains disabled throughout a continuous period of at least 12 months, DAA is not material even if the claimant's impairment(s) is gradually improving.

[27] The DSM-IV-TR provides "specifiers" describing the length and nature of remissions. For example, the specifier for a sustained full remission applies if the claimant has not evidenced any of the criteria for dependence or abuse at any time for at least 12 months. We do not require that a period of abstinence satisfy the criteria for sustained full remission or any of the other specifiers in the DSM.

[28] At the hearings and appeals levels of the administrative review process, ALJs and the Appeals Council may seek assistance from medical experts in interpreting the medical evidence regarding the separate effects of treatment for DAA and a co-occurring mental disorder(s).

[29] See, for example, section 12.00F in the mental disorders listings for adults, 20 CFR part 404, subpart P, appendix 1.

[30] The symptoms and signs of a co-occurring mental disorder or even symptoms of some physical impairments will not necessarily abate with abstinence. Sometimes, withdrawal of the substance(s) may result in a worsening of the symptoms and signs attributable to the other impairment(s); for example, increased anxiety or pain.

[31] See SSR 82-59. Our rules provide in part that, for failure to follow prescribed treatment to apply, the claimant must be "disabled" and a treating source must have prescribed treatment that is "clearly expected" to restore the claimant's capacity to do substantial gainful activity. The claimant must also not have good cause for failing to follow the prescribed treatment.

[32] *See* SSR 96-1p. In a class action decided by a district court, we will issue instructions to adjudicators on how to apply the court's decision. Even in this circumstance, adjudicators must not interpret the decision for themselves because their interpretation may conflict with the agency's interpretation.

Back to Table of Contents

Drug Addiction & Alcohol Cases (DAA)

Analyzing DAA Cases:

1. **DAA must be a medically determinable severe impairment for DAA analysis to be relevant**
    a. **Must be diagnosed by an acceptable medial resource** - A reference in the records to drug and/or alcohol use is not enough to establish it as a severe impairment.
    b. **Substance abuse disorder is no longer considered a mental impairment** under the revised mental listings.
    c. **DAA disorder severity** -- Information from "other" sources may be helpful in documenting the severity of DAA because it supplements the medical evidence of record.
        i. Opinions from "other" sources can assist in evaluating whether DAA is material to a finding of disability because it can document how well the claimant performs activities of daily living in the presence of a comorbid impairment.
        ii. Often, evidence from "other" sources may be the most important information in the case record for these documentation issues.

2. **If DAA Disorder diagnosis?** Is the claimant disabled, considering *ALL* impairments?
    a. NO (not disabled) - DAA is not material and no analysis required.
    b. YES (disabled)- DAA may be material, and DAA analysis required.
        i. **Considering *ALL* impairments except DAA disorder -** Apply the sequential evaluation.
            1. Is claimant still disabled?
                a. YES - DAA is not material.
                b. NO - DAA is material.
        ii. **Burden of Proof** - The claimant has the burden of proving disability throughout the DAA materiality analysis.

DA&A Points to Remember:

- **Consider the relevance of DAA** if you find it to be a severe impairment.
- **Cite to specific evidence** in the record to support a finding that DAA is material/not material. If you find DAA material, there must be evidence in the record showing that, if the claimant stopped drinking/taking drugs, his condition would improve to the point that he would not be disabled.
- **For DAA Material finding, your decision must reflect** the following information:
    - The **step in the sequential evaluation** where the claimant is **found disabled**; and
    - The **step in the sequential evaluation** where the claimant is **found not disabled** if the claimant stopped using drugs or alcohol.

- **Specifically, explain "B" Criteria ratings.**
- **DAA analysis** – Focus on if the claimant would be disabled even if the claimant stopped using drugs or alcohol (not whether claimant disabled while using DAA).
- A finding that claimant **is disabled during a period of abstinence is inconsistent** with a finding that DAA is material.
- **If DAA is the only severe impairment and claimant is disabled? DAA is material.**
- **In redetermination cases**, DAA is adjudicated in the same manner as an initial case, since the appeal of the termination is treated as a new application for benefits.

Resources:

- 20 C.F.R. §§ 404.1535 and 416.935
- Social Security Ruling (SSR) 13-2p: *Titles II and XVI: Evaluating Cases Involving Drug Addiction and Alcoholism (DAA)*
- Appeals Council Feedback Training - Drug Addiction and Alcoholism
- New Administrative Law Judge (ALJ)/Decision Writer (DW) Training Module 14 ("DA and A")
- Office of Hearings Operations (OHO) Continuing Education Program (OCEP) 7/16/14: DAA - *Drug Addiction and Alcoholism (DAA) (VOD)*
- *OCEP 4 Keys to DAA*
- Disability Analysis Flow Chart: DA&A Evaluation Process Flow Chart

The Four Keys to DAA

You must determine if DAA is a medically determinable severe impairment.

- Evidence of drug or alcohol use alone does not establish DAA as a medically determinable severe impairment. Evidence from an acceptable medical source is necessary.
- DAA is a "substance use disorder" defined as a "maladaptive pattern of substance use that leads to clinically significant impairment or distress."

If you find the claimant disabled considering all impairments, including DAA, use the six-step evaluation process under SSR 13-2p to determine if DAA is material.

- If the claimant is not disabled considering all impairments, including DAA, your evaluation is finished. DAA materiality is not an issue.
- If the claimant is disabled considering all impairments, including DAA, you must conduct a second sequential evaluation considering all impairments except DAA to determine if DAA is material.
- The claimant has the burden of proving disability throughout the sequential evaluation process.

Recognize and avoid common DAA errors.

- Failure to cite specific evidence to support a finding that DAA is material to the finding of disability;
- Failure to explain the "B" criteria findings;
- Finding the claimant disabled only during a period of abstinence; and,
- Failure to evaluate DAA when it is a severe impairment.

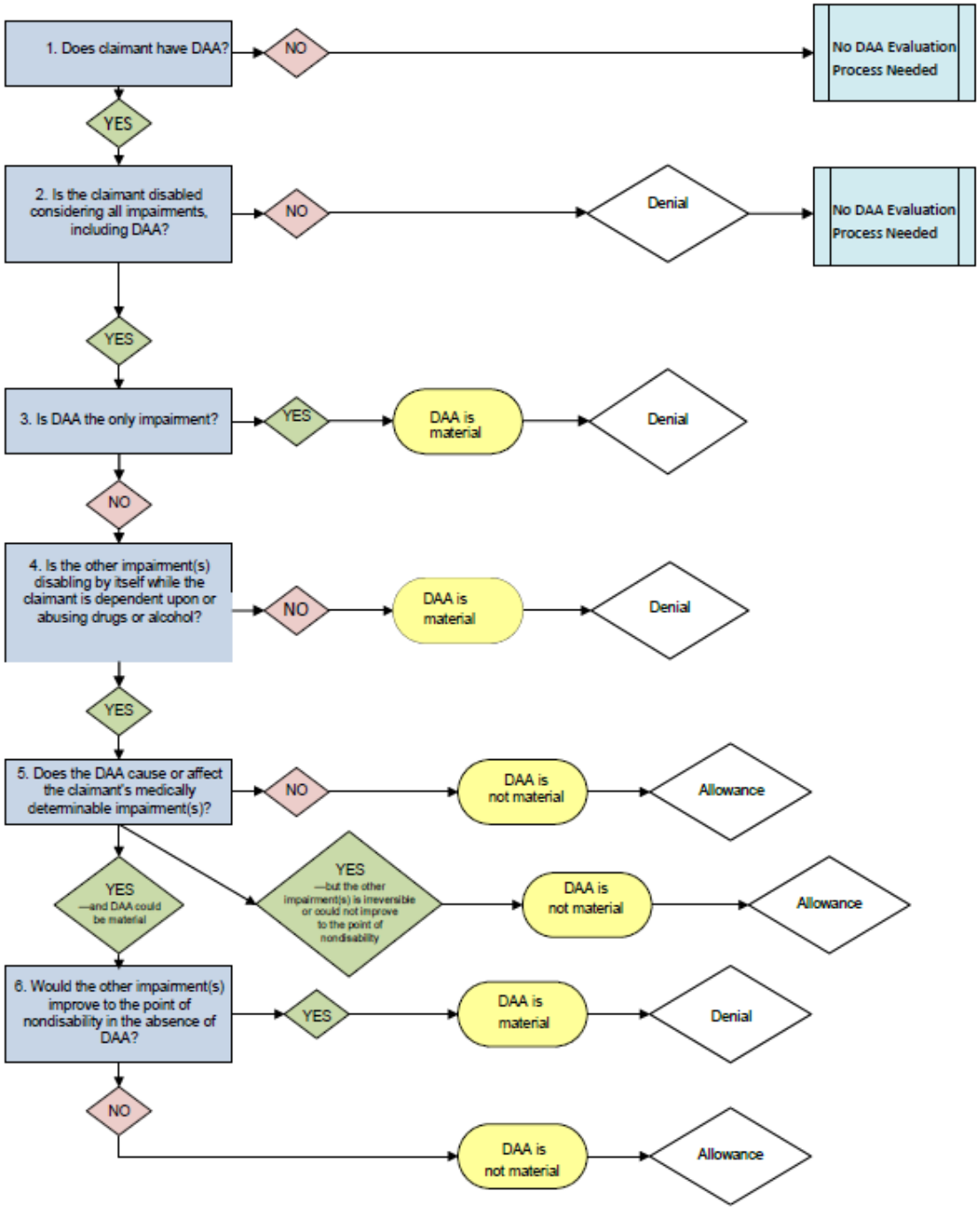
Decision instructions and drafts must identify specific evidence showing whether DAA is material.

- A statement in the decision that DAA is, or is not, material to the determination is insufficient. The decision must cite evidence in support of this finding.

DAA Evaluation Process – Flow Chart

DAA Evaluation Process

As in all DAA materiality determinations, apply the appropriate sequential evaluation process twice. If the claimant's only MDI is DAA, find that DAA is material to the determination of disability and deny the claim.



SSR 18-3p: Failure to Follow Prescribed Treatment

Sarah H. Bohr, Sarah Bohr's Pocket Guide to Key Social Security Rulings Tenth Edition (2019)

A. Topics addressed

- Concerns a claimant's failure to follow prescribed treatment
- Rescinds and replaces SSR 82-59
- Sets forth the three conditions which must be met in order to find that a claimant has failed to follow prescribed treatment
- Explains what constitutes prescribed treatment
- Describes situations in which there is good cause for the failure to follow treatment
- Discusses the types of cases to which the policy applies
- Provides that predetermination notices are required in some cases

B. Overview of Ruling

Effective October 29, 2018, SSR 18-03p, which rescinds and replaces SSR 82-59, describes how the agency applies its policy concerning a claimant's failure to follow prescribed treatment. Under this policy, at any level of the administrative process, a claimant otherwise entitled to benefits might be denied benefits based on disability or blindness or have benefits terminated if evidence indicates that the claimant's own medical source prescribed treatment for an impairment on which the disability finding is based; and evidence indicates

that the claimant did not follow the prescribed treatment.

If all of these conditions are met, SSA will make a failure to follow treatment determination by assessing whether the treatment, if followed, would be expected to restore the claimant's ability to engage in SGA, and whether there was good cause for not following the prescribed treatment. If the agency makes a failure to follow prescribed treatment determination, it must explain the basis for its findings in its determination or decision.

The Ruling explains that if the failure to follow treatment occurred more than 12 months after onset, the individual will be found disabled with a closed period ending with the failure to follow prescribed treatment. For a title XVI blindness claim with the failure occurring after the first day of the month after filing, however, the closed period spans "from the date of entitlement until the date we determined the individual failed to follow the prescribed treatment without good cause." SSR 18-03p also discusses the role of a failure to follow prescribed treatment in claims involving drug addiction and alcoholism ("DAA").

With regard to step 3 of the sequential evaluation process, the Ruling explains that there are two situations where no failure to follow prescribed treatment determination will be made even if there is evidence that an individual failed to follow prescribed treatment. First, "when we find the individual disabled based on a listing that requires only the presence of laboratory findings" and second, where "the individual is disabled based on a listed impairment(s) which requires" consideration of "whether the individual was following that specific treatment as part of the required listing analysis." The Ruling also discusses how child claims are handled in cases where there is a potential failure to follow prescribed treatment, and explains that the same exceptions just described apply equally to these claims.

When the agency reopens a determination or decision and finds that an individual does not have good cause for failing to follow prescribed treatment, it "will issue a predetermination notice and offer the individual an opportunity to respond before we terminate benefits." Similarly, when conducting a continuing disability review ("CDR"), such a finding will trigger a predetermination notice and offer of an opportunity to respond before benefits are terminated.

C. Key Components

1. A failure to follow prescribed treatment without good cause may result in claim denial.

   For initial claims, an individual can only be found to have failed to follow prescribed treatment if (1) the person would otherwise be entitled to disability or blindness benefits; (2) there is evidence that the individual's own medical source prescribed treatment for an impairment on which the disability finding is based; and (3) there is evidence that the individual did not follow the prescribed treatment. If all three conditions exist, the agency must then assess whether the prescribed treatment, if followed, would be expected to restore the claimant's ability to engage in SGA and, if so, whether he or she has good cause for not following the prescribed treatment. The agency may choose to make the good cause assessment first, and this will not change the analysis. All relevant evidence must be considered to determine whether the agency would expect the prescribed treatment, if followed, to restore the individual's ability to engage in SGA.

2. Prescribed treatment must be from one of the claimant's own medical sources.

   The treatment must have been prescribed by one of the claimant's own medical sources. Therefore, the Ruling explains, the agency will not find a failure "to follow prescribed treatment if the treatment was prescribed only by a consultative examiner (CE), medical consultant (MC), psychological consultant (PC), medical expert (ME), or by a medical source during an evaluation conducted solely to determine eligibility to any State or Federal benefit."

3. Prescribed treatment does not refer to lifestyle modifications.

   Prescribed treatment means any medication, surgery, therapy, use of durable medical equipment, or use of assistive devices. Prescribed treatment does not include lifestyle modifications, such as dieting, exercise, or smoking cessation.

4. Past prescribed treatment may be relevant.

   The Ruling explains that it will consider treatment prescribed in the past if the "treatment is still relevant to

the individual's medically determinable impairments that are present during the potential period of entitlement or eligibility and upon which the disability finding was based." However, a failure to follow the treatment will only be evaluated for the period during which there may be entitlement to benefits.

5. The burden of showing good cause for failure to follow treatment is on the claimant/parent.

   In adult claims, the individual has the burden to provide evidence showing that he or she has good cause for failing to follow prescribed treatment. In child claims, the burden rests with the parent or guardian to show that the child has good cause.

   To assess good cause, the agency must develop the claim according to the detailed instructions in the Ruling's procedures section, which should be consulted for each case as needed.

   Examples of acceptable good cause reasons include reasons relating to religion, cost, incapacity, medical disagreement among the claimant's treating sources, intense fear of surgery, prior history of unsuccessful surgery, high risk of loss of life or limb, and risk of addiction to opioid medication.

6. Failure to follow treatment might not bar benefits where a listing is satisfied.

   With regard to step 3 of the sequential evaluation process, the Ruling explains that there are two situations where no failure to follow prescribed treatment determination will be made even if there is evidence that an individual failed to follow prescribed treatment. First, "when we find the individual disabled based on a listing that requires only the presence of laboratory findings" and second, where "the individual is disabled based on a listed impairment(s) which requires" consideration of "whether the individual was following that specific treatment as part of the required listing analysis." The Ruling also discusses how child claims are handled in cases where there is a potential failure to follow prescribed treatment, and explains that the same exceptions just described apply equally to these claims.

Effective Date:
October 29, 2018
Federal Register, vol. 83, No, 191, page 49616.

Policy Interpretation Ruling

SSR 18-3p: Titles II and XVI: Failure to Follow Prescribed Treatment

This Social Security Ruling (SSR) rescinds and replaces SSR 82-59: "Titles II and XVI: Failure to Follow Prescribed Treatment."

Purpose: To provide guidance on how we apply our failure to follow prescribed treatment policy in disability and blindness claims under titles II and XVI of the Social Security Act (Act).

Citations (Authority): Sections 216(i), 223(d) and (f), and 1614(a) of the Act, as amended; 20 CFR 404.1530 and 416.930.

Dates: We will apply this notice on October 29, 2018.[1]

Overview

A. Background

Under the Act, an individual who meets the requirements to receive disability or blindness benefits will not be entitled to these benefits if the individual fails, without good cause, to follow prescribed treatment that we expect would restore his or her ability to engage in substantial gainful activity (SGA).[1]

We apply the failure to follow prescribed treatment policy at all levels of our administrative review process when we decide an initial claim for benefits based on disability or blindness. We also apply the policy when we reopen a prior determination or decision involving a claim for benefits based on disability or blindness, when we conduct an age-18 redetermination, and when we conduct a continuing disability review (CDR) under titles II or XVI of the Act.

This SSR explains the policy and procedures we follow when we decide whether an individual has failed to follow prescribed treatment as required by the Act and our regulations.[2]

B. When we decide whether the failure to follow prescribed treatment policy may apply in an initial claim

We will determine whether an individual has failed to follow prescribed treatment only if all three of the following conditions exist:

1.The individual would otherwise be entitled to benefits based on disability or eligible for blindness benefits under titles II or XVI of the Act;

2.We have evidence that an individual's own medical source(s) prescribed[3]treatment for the medically determinable impairment(s) upon which the disability finding is based; and

3.We have evidence that the individual did not follow the prescribed treatment.

If all three conditions exist, we will determine whether the individual failed to follow prescribed treatment, as explained below.[4]

Condition 1: The individual is otherwise entitled to disability or statutory blindness benefits under Titles II or XVI of the Act

We only perform the failure to follow prescribed treatment analysis discussed in this SSR after we find that an individual is entitled to disability or eligible for statutory blindness benefits under titles II or XVI of the Act, regardless of whether the individual followed the prescribed treatment. We will not determine whether an individual failed to follow prescribed treatment if we find the individual is not disabled, not blind, or otherwise not entitled to or eligible for benefits under titles II or XVI of the Act.

Condition 2: There is evidence that an individual's own medical source(s) prescribed treatment for the medically determinable impairment(s) upon which the disability finding is based

If we find that the individual is otherwise entitled to disability or eligible for statutory blindness benefits under titles II or XVI of the Act, we will only determine if the individual has failed to follow prescribed treatment for the medically determinable impairment(s) upon which the disability finding is based if the individual's own medical source(s) prescribed the treatment.[5] We will not determine whether the individual failed to follow prescribed treatment if the treatment was prescribed only by a consultative examiner (CE), medical consultant (MC), psychological consultant (PC), medical expert (ME), or by a medical source during an evaluation conducted solely to determine eligibility to any State or Federal benefit.

Prescribed treatment means any medication, surgery, therapy, use of durable medical equipment, or use of assistive devices. Prescribed treatment does not include lifestyle modifications, such as dieting, exercise, or smoking cessation. We will consider any evidence of prescribed treatment, whether it appears on prescription forms or is otherwise indicated within a medical source's records.

We will consider treatment a medical source prescribed in the past if that treatment is still relevant to the individual's medically determinable impairments that are present during the potential period of entitlement or eligibility and upon which the disability finding was based. We will evaluate whether the individual failed to follow the prescribed treatment, and whether there is good cause for this failure, only for the period(s) during which the individual may be entitled to benefits under the Act.

For example: On January 2, 2017, an individual filed for disability benefits based on an impairment related to a lower-extremity amputation. The individual is no longer wearing a prosthesis that her medical source prescribed in 2015. We determine that the individual meets all of the other criteria for disability. In this scenario, we will evaluate whether the individual is failing to follow the prescribed treatment to wear the prosthesis during the potential entitlement period and whether the individual has good cause for not following the prescribed treatment during this period. However, we will not consider whether the individual failed to follow prescribed treatment prior to the first possible date of entitlement.

Condition 3: There is evidence that the individual did not follow the prescribed treatment

If we have any evidence that the individual is not following the prescribed treatment, this condition is satisfied. For example, a medical source may include in a treatment note that the patient has not been compliant with a prescribed medication regimen.

C. How we will make a failure to follow prescribed treatment determination

If all three conditions exist, we will determine whether the individual has failed to follow prescribed treatment in the claim. To make a failure to follow prescribed treatment determination, we will:

1. Assess whether the prescribed treatment, if followed, would be expected to restore the individual's ability to engage in SGA.
2. Assess whether the individual has good cause for not following the prescribed treatment.

We may make either assessment first. If we first assess that the prescribed treatment, if followed, would not be expected to restore the individual's ability to engage in SGA, then it is unnecessary for us to assess whether the individual had good cause. Similarly, if we first assess that an individual has good cause for not following the prescribed treatment, then it is unnecessary for us to assess whether the prescribed treatment, if followed, would be expected to restore the individual's ability to engage in SGA.

Assessment 1: We assess whether the prescribed treatment, if followed, would be expected to restore the individual's ability to engage in SGA

This assessment focuses on the prescribed treatment. We will determine whether we would expect the prescribed treatment, if followed, to restore the individual's ability to engage in SGA. We are responsible for making this assessment, and we will consider all the relevant evidence in the record. At the initial and reconsideration levels of the administrative review process, an MC or PC will make this assessment. At the hearings and Appeals Council (AC) levels, the adjudicator(s) will make this assessment. Although the conclusion of this assessment ultimately rests with us, we will consider the prescribing medical source's prognosis.

If we first determine that following the prescribed treatment would not be expected to restore the individual's ability to engage in SGA, then it is unnecessary for us to assess whether the individual had good cause for failing to follow the prescribed treatment. If we determine that following the prescribed treatment would restore the individual's ability to engage in SGA, we will then assess whether the individual has good cause for not following the prescribed treatment.

Assessment 2: We assess whether the individual has good cause for not following the prescribed treatment

This assessment focuses on whether the individual has good cause for not following the prescribed treatment.

In adult claims, the individual has the burden to provide evidence showing that he or she has good cause for failing to follow prescribed treatment.

In child claims, the parent or guardian has the burden to provide evidence showing that the child has good cause for failing to follow prescribed treatment. If the child has a representative payee and the parent, guardian, or child asserts that the child would have followed prescribed treatment but for the actions of the representative payee, we

will determine whether to obtain a new representative payee. If we decide to obtain a new representative payee, we will provide additional time for the child to follow the prescribed treatment before we continue considering the claim.

To assess good cause in both adult and child claims, we will develop the claim according to the instructions in the *Development procedures* section below. The following are examples of acceptable good cause reasons for not following prescribed treatment:

1. *Religion*: The established teaching and tenets of the individual's religion prohibit him or her from following the prescribed treatment. The individual must identify the religion, provide evidence of the individual's membership in or affiliation to his or her religion, and provide evidence that the religion's teachings do not permit the individual to follow the prescribed treatment.
2. *Cost*: The individual is unable to afford prescribed treatment, which he or she is willing to follow, but for which affordable or free community resources are unavailable. Some individuals can obtain free or subsidized health insurance plans or healthcare from a clinic or other provider. In these instances, the individual must demonstrate why he or she does not have health insurance that pays for the prescribed treatment or why he or she failed to obtain treatment at the free or subsidized healthcare provider.
3. *Incapacity*: The individual is unable to understand the consequences of failing to follow prescribed treatment.
4. *Medical disagreement*: When the individual's own medical sources disagree about whether the individual should follow a prescribed treatment, the individual has good cause to not follow the prescribed treatment. Similarly, when an individual chooses to follow one kind of treatment prescribed by one medical source to the simultaneous exclusion of an alternate treatment prescribed by another medical source, the individual has good cause not to follow the alternate treatment.
5. *Intense fear of surgery*: The individual's fear of surgery is so intense that it is a contraindication to having the surgery. We require a written statement from an individual's own medical source affirming that the individual's intense fear of surgery is in fact a contraindication to having the surgery. We will not consider an individual's refusal of surgery as good cause for failing to follow

prescribed treatment if it is based on the individual's assertion that success is not guaranteed or that the individual knows of someone else for whom the treatment was not successful.

6. *Prior history*: The individual previously had major surgery for the same impairment with unsuccessful results and the same or similar additional major surgery is now prescribed.
7. *High risk of loss of life or limb*: The treatment involves a high risk for loss of life or limb. Treatments in this category include:
    - Surgeries with a risk of death, such as open-heart surgery or organ transplant.
    - Cataract surgery in one eye with a documented, unusually high-risk of serious surgical complications when the individual also has a severe visual impairment of the other eye that cannot be improved through treatment.
    - Amputation of an extremity or a major part of an extremity.
8. *Risk of addiction to opioid medication*: The prescribed treatment is for opioid medication.
9. *Other*: If the individual offers another reason for failing to follow prescribed treatment, we will determine whether it is reasonably justified on a case-by- case basis.

We will not consider as good cause an individual's allegation that he or she was unaware that his or her own medical source prescribed the treatment, unless the individual shows incapacity as described above. Similarly, mere assertions or allegations about the effectiveness of the treatment are insufficient to meet the individual's burden to show good cause for not following the prescribed treatment.

D. Development procedures

If evidence we already have in a claim is insufficient to make the required assessment(s) in the failure to follow prescribed treatment determination, we may develop the evidence, as appropriate. This development could include contacting the individual's medical source(s) or the individual to ask why he or she did not follow the prescribed treatment. Although it may be helpful to have evidence from a CE or ME, we are not required to purchase a CE or obtain testimony from an ME to help us determine whether we expect a prescribed treatment, if followed, would restore the ability to engage in SGA. We are responsible for resolving any conflicts in the evidence, including inconsistencies between

statements made by the individual and information received from his or her medical source(s). We may also evaluate the claim using the procedures for fraud or similar fault, if appropriate.

E. Required written statement of failure to follow prescribed treatment determination

When we make a failure to follow prescribed treatment determination, we will explain the basis for our findings in our determination or decision.

F. When we make a failure to follow prescribed treatment determination within the sequential evaluation process for initial claims

Adult claims that meet or equal a listing at step 3

Generally, if we find that an individual's impairment(s) meets or medically equals a listing at step 3 of the sequential evaluation process, and there is evidence of all three conditions listed in Section B above, we will determine whether the individual failed to follow prescribed treatment. We will determine whether an individual would still meet or medically equal a listing had he or she followed the prescribed treatment. If we determine the individual would no longer meet or medically equal the listing had he or she followed prescribed treatment, we will assess whether there is good cause for not following the prescribed treatment. We will determine that the individual is disabled if we find that he or she has good cause for not following the prescribed treatment. If we do not find good cause, we will continue to evaluate the claim using the sequential evaluation process by determining the individual's residual functional capacity (RFC).[6]

There are two instances when we will not make a failure to follow prescribed treatment determination at step 3 of the sequential evaluation process, even if there is evidence that an individual did not follow prescribed treatment. First, we will not make a failure to follow prescribed treatment determination when we find the individual disabled based on a listing that requires only the presence of laboratory findings. In these claims, treatment would have no effect on the disability determination or decision. Second, we will not make a failure to follow prescribed treatment determination when we find the individual is disabled based on a listed impairment(s) which requires us to consider whether the individual was following that specific treatment as part of the required listing analysis. If either of these exceptions apply, we will

find the individual is disabled without making a failure to follow prescribed treatment determination.

Title XVI child claims that meet, medically equal, or functionally equal the listings at step 3

Generally, if we find that a child's impairment(s) meets, medically equals, or functionally equals the listings at step 3 of the sequential evaluation process, and there is evidence of all three conditions listed in Section B above, we will determine whether there has been a failure to follow prescribed treatment. We will determine whether the child's impairment(s) would still meet, medically equal, or functionally equal the listings had he or she followed the prescribed treatment. If we determine the child's impairment(s) would no longer meet, medically equal, or functionally equal the listings had he or she followed prescribed treatment, we will assess whether there is good cause for not following the prescribed treatment. We will find the child is disabled if we determine that he or she has good cause for not following the prescribed treatment. If we determine that there is not good cause for failing to following the prescribed treatment, we will find the child is not disabled.

There are two instances when we will not make a failure to follow prescribed treatment determination at step 3 of sequential evaluation process even if there is evidence that a child did not follow prescribed treatment. First, we will not make a failure to follow prescribed treatment determination when we find the child is disabled based on a listing that requires only the presence of laboratory findings. In these claims, treatment would have no impact on the disability determination or decision. Second, we will not make a failure to follow prescribed treatment determination when we find the child is disabled based on a listed impairment(s) which requires us to consider whether the child was following that specific treatment as part of the required listing analysis. If either of these exceptions apply, we will find the child is disabled without making a failure to follow prescribed treatment determination.

Adult claims finding disability at step 5

If we find that an individual is disabled at step 5 of the sequential evaluation process and there is evidence the individual is not following treatment prescribed by his or her own medical source(s), before we find the individual is disabled, we will assess whether the individual would still be disabled if he or she were following the prescribed treatment.

We will determine what the individual's residual functional capacity (RFC) would be had he or she followed the prescribed treatment. We will then use that RFC to reevaluate steps 4 and 5 of the sequential

evaluation process to determine whether the individual could perform his or her past relevant work at step 4 or adjust to other work at step 5. We will find the individual is disabled if we determine that the individual would remain unable to engage in SGA, even if the individual had followed the prescribed treatment. We will also find the individual is disabled if we find the individual had good cause for not following the prescribed treatment. However, we will find the individual is not disabled if the individual does not have good cause for not following the prescribed treatment and we determine that, had the individual followed the prescribed treatment, he or she could perform past relevant work or engage in other SGA.

G. Reopening a determination or decision

As permitted by our regulations, we may reopen a favorable determination or decision if we discover we did not apply the failure to follow prescribed treatment policy correctly.[7] We may base our reopening on the evidence we had in the folder at the time we made our determination or decision or based on new evidence we receive. When we reopen a disability or blindness determination or decision and find that an individual does not have good cause for failing to follow prescribed treatment, we will issue a predetermination notice and offer the individual an opportunity to respond before we terminate benefits.

H. Continuing Disability Reviews (CDR)

When we conduct a CDR, we will make a failure to follow prescribed treatment determination when the individual's own medical source(s) prescribed a new treatment for the disabling impairment(s) since the last favorable determination or decision and the individual did not follow the prescribed treatment.

We will also make a failure to follow prescribed treatment determination during a CDR if we find that an individual would continue to be entitled to disability or blindness benefits based upon an impairment first alleged during the CDR and there is evidence that the individual has not followed his or her own medical source's prescribed treatment for that impairment.

If we determine an individual does not have good cause for failing to follow the prescribed treatment that we have determined would restore the individual's ability engage in SGA, we will issue a predetermination notice and, because benefits may be terminated, offer the individual an opportunity to respond before terminating benefits. Individuals are entitled to benefits while we develop evidence to determine whether they

failed to follow prescribed treatment. If we determine that an individual failed to follow prescribed treatment without good cause in either situation, we will cease benefits two months after the month of the determination or decision that the individual is no longer disabled or statutorily blind.

I. Duration in disability and Title II blindness claims

If an individual failed to follow the prescribed treatment without good cause within 12 months of onset of disability or blindness, we will find the individual is not disabled because the duration requirement is not met.[8] However, if an individual failed to follow prescribed treatment without good cause more than 12 months after onset of disability or blindness and is otherwise disabled, we will find the individual is disabled with a closed period that ends when the individual failed to follow the prescribed treatment. In this situation, we will continue to pay benefits as usual through the second month after the month disability or blindness ends.

J. Duration in Title XVI blindness claims

Because title XVI blindness entitlement does not have a duration requirement, an individual meeting the title XVI blindness requirements may be entitled to benefits beginning the month after he or she applies for benefits.[9] If we determine an individual failed to follow prescribed treatment without good cause any time before the first day of the month after filing, we will find the individual is not disabled. However, if we determine the individual failed to follow prescribed treatment without good cause any time after the first day of the month after filing, we will find the individual is disabled with a closed period from the date of entitlement until the date we determined the individual failed to follow the prescribed treatment without good cause. In this situation, we will continue to pay benefits as usual through the second month after the month blindness ends.

If we need further development to determine whether a title XVI blind individual failed to follow prescribed treatment without good cause, the individual is entitled to benefits while we conduct the additional development. At the hearing and Appeals Council levels, we will refer the claim to the effectuating component to develop the evidence necessary to make a failure to follow prescribed treatment determination.

K. Claims involving both drug addiction and alcoholism (DAA) and failure to follow prescribed treatment

In a claim that may involve both DAA and failure to follow a prescribed treatment for an impairment other than DAA, we will first make the DAA determination.[10] If we find that the individual is disabled considering all impairments including the DAA and that DAA is material to our determination of disability, we will deny the claim and not make a failure to follow prescribed treatment determination. If we find that the individual is disabled considering all impairments including the DAA, but the DAA is not material to our determination of disability, we will then make the failure to follow prescribed treatment determination for the impairment(s) other than DAA. Even if the prescribed treatment for the other impairment(s) may also have beneficial effect on the DAA, we do not reevaluate for DAA materiality a second time.

For example, we cannot find that an individual has failed to follow prescribed treatment for liver disease based on a failure to follow treatment prescribed for alcohol dependence. If the cessation of drinking alcohol would be expected to improve the individual's functioning so that he or she is not disabled, we would find that DAA is material to the determination of disability and deny the claim for that reason.

---

[1] Our adjudicators will apply this ruling when we make determinations and decisions on or after October 29, 2018. When a Federal court reviews our final decision in a claim, we expect the court will review the final decision using the rules that were in effect at the time we issued the decision under review. If a court finds reversible error and remands a case for further administrative proceedings on or after October 29, 2018, the applicable date of this ruling, we will apply this ruling to the entire period at issue in the decision we make after the court's remand. Our regulations on failure to follow prescribed treatment are unchanged.

[2] Sections 223(f) and 1614(a) of the Act. The ability to engage in SGA is the standard in adult disability claims. However, when this policy is applied in title XVI child disability claims, the standard is "the prescribed treatment is expected to eliminate or improve the child's impairment so that it no longer results in marked and severe functional limitations." Similarly, for claims based on statutory blindness, the standard is the prescribed treatment would be expected to "restore vision to the extent that the individual will no longer be blind."

[3] See 20 CFR 404.1530 and 416.930.

[4] There are two exceptions at step 3 of the sequential evaluation process, explained in section F (below), when we will not make a failure to follow prescribed treatment determination even if these three

[5] See 20 CFR 404.1502 and 416.902 for the definition of "medical source."

[6] See 20 CFR 404.1545 and 416.945.

[7] See 20 CFR 404.988, 404.989, 416.1488, and 416.1489.

[8] See 20 CFR 404.1509 and 416.909.

[9] Section 216(i)(1)(B) of the Act.

[10] See SSR 13-2p: Titles II and XVI: Evaluating Cases Involving Drug Addiction and Alcoholism (DAA), 78 FR 11939 (Mar. 22, 2013).

Back to Table of Contents