

designated to perform the consultative examination.

[56 FR 36957, Aug. 1, 1991, as amended at 65 FR 11876, Mar. 7, 2000; 71 FR 16444, Mar. 31, 2006; 76 FR 24806, May 3, 2011]

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

The medical sources who perform consultative examinations will have a good understanding of our disability programs and their evidentiary requirements. They will be made fully aware of their responsibilities and obligations regarding confidentiality as described in § 401.105(e). We will fully inform medical sources who perform consultative examinations at the time we first contact them, and at subsequent appropriate intervals, of the following obligations:

(a) *Scheduling.* In scheduling full consultative examinations, sufficient time should be allowed to permit the medical source to take a case history and perform the examination, including any needed tests. The following minimum scheduling intervals (*i.e.*, time set aside for the individual, not the actual duration of the consultative examination) should be used.

(1) Comprehensive general medical examination—at least 30 minutes;

(2) Comprehensive musculoskeletal or neurological examination—at least 20 minutes;

(3) Comprehensive psychiatric examination—at least 40 minutes;

(4) Psychological examination—at least 60 minutes (Additional time may be required depending on types of psychological tests administered); and

(5) All others—at least 30 minutes, or in accordance with accepted medical practices.

We recognize that actual practice will dictate that some examinations may require longer scheduling intervals depending on the circumstances in a particular situation. We also recognize that these minimum intervals may have to be adjusted to allow for those claimants who do not attend their scheduled examination. The purpose of these minimum scheduling timeframes is to ensure that such examinations are complete and that sufficient time is

made available to obtain the information needed to make an accurate determination in your case. State agencies will monitor the scheduling of examinations (through their normal consultative examination oversight activities) to ensure that any overscheduling is avoided, as overscheduling may lead to examinations that are not thorough.

(b) *Report content.* The reported results of your medical history, examination, requested laboratory findings, discussions and conclusions must conform to accepted professional standards and practices in the medical field for a complete and competent examination. The facts in a particular case and the information and findings already reported in the medical and other evidence of record will dictate the extent of detail needed in the consultative examination report for that case. Thus, the detail and format for reporting the results of a purchased examination will vary depending upon the type of examination or testing requested. The reporting of information will differ from one type of examination to another when the requested examination relates to the performance of tests such as ventilatory function tests, treadmill exercise tests, or audiological tests. The medical report must be complete enough to help us determine the nature, severity, and duration of the impairment, and residual functional capacity. The report should reflect your statement of your symptoms, not simply the medical source's statements or conclusions. The medical source's report of the consultative examination should include the objective medical facts as well as observations and opinions.

(c) *Elements of a complete consultative examination.* A complete consultative examination is one which involves all the elements of a standard examination in the applicable medical specialty. When the report of a complete consultative examination is involved, the report should include the following elements:

(1) Your major or chief complaint(s);

(2) A detailed description, within the area of specialty of the examination, of the history of your major complaint(s);

(3) A description, and disposition, of pertinent "positive" and "negative"

detailed findings based on the history, examination and laboratory tests related to the major complaint(s), and any other abnormalities or lack thereof reported or found during examination or laboratory testing;

(4) The results of laboratory and other tests (e.g., X-rays) performed according to the requirements stated in the Listing of Impairments (see appendix 1 of this subpart P);

(5) The diagnosis and prognosis for your impairment(s);

(6) A statement about what you can still do despite your impairment(s), unless the claim is based on statutory blindness. This statement should describe the opinion of the medical source about your ability, despite your impairment(s), to do work-related activities, such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling; and, in cases of mental impairment(s), the opinion of the medical source about your ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers and work pressures in a work setting. Although we will ordinarily request, as part of the consultative examination process, a medical source statement about what you can still do despite your impairment(s), the absence of such a statement in a consultative examination report will not make the report incomplete. See § 404.1527; and

(7) In addition, the medical source will consider, and provide some explanation or comment on, your major complaint(s) and any other abnormalities found during the history and examination or reported from the laboratory tests. The history, examination, evaluation of laboratory test results, and the conclusions will represent the information provided by the medical source who signs the report.

(d) *When a complete consultative examination is not required.* When the evidence we need does not require a complete consultative examination (for example, we need only a specific laboratory test result to complete the record), we may not require a report containing all of the elements in paragraph (c).

(e) *Signature requirements.* All consultative examination reports will be personally reviewed and signed by the medical source who actually performed the examination. This attests to the fact that the medical source doing the examination or testing is solely responsible for the report contents and for the conclusions, explanations or comments provided with respect to the history, examination and evaluation of laboratory test results. The signature of the medical source on a report annotated “not proofed” or “dictated but not read” is not acceptable. A rubber stamp signature of a medical source or the medical source’s signature entered by any other person is not acceptable.

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§ 404.1519c When a properly signed consultative examination report has not been received.

If a consultative examination report is received unsigned or improperly signed we will take the following action.

(a) *When we will make determinations and decisions without a properly signed report.* We will make a determination or decision in the circumstances specified in paragraphs (a)(1) and (a)(2) of this section without waiting for a properly signed consultative examination report. After we have made the determination or decision, we will obtain a properly signed report and include it in the file unless the medical source who performed the original consultative examination has died:

(1) Continuous period of disability allowance with an onset date as alleged or earlier than alleged; or

(2) Continuance of disability.

(b) *When we will not make determinations and decisions without a properly signed report.* We will not use an unsigned or improperly signed consultative examination report to make the determinations or decisions specified in paragraphs (b)(1), (b)(2), (b)(3), and (b)(4) of this section. When we need a properly signed consultative examination report to make these determinations or decisions, we must obtain such a report. If the signature of the medical source who performed the original