



CONSORTIUM FOR CITIZENS WITH DISABILITIES

Improving Decision Making at the
Disability Determination Services

It is in the interest of all parties involved for the Social Security Administration to make the right decision as early as possible during the adjudicative process in a disability claim that will eventually be awarded. The failure to approve a claim for Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) benefits during the initial review of a claim when the individual meets the statutory eligibility requirements harms claimants by delaying access to vital income support and potentially leading to unnecessary preventable harm to the claimant (e.g. homelessness, bankruptcy, deteriorating health due to lack of access to medical care) and is administratively inefficient for the agency to be required to dedicate resources to an additional level (or additional levels) of review if the claim could have been approved earlier.

It is the position of the CCD Social Security Task Force that the state Disability Determination Services (DDS) should only review a claim one time and that the current second level of review they perform, called reconsideration, be eliminated. SSA should focus all the resources currently provided to DDSes to what is currently the initial application phase of the adjudication process and ensure that those initial decisions made by the DDS are made based on a more complete evidentiary record that contains more specific, tailored information to better aid those decisionmakers in making policy compliant decisions that correctly determine which claimants meet the statutory definition of disability.

The recommendations contained in this document have been developed to improve initial disability decisions made at a DDS but could also be applied to reconsideration should that stage of appeal be retained.

Lack of publicly available data limits ability to make recommendations: The recommendations of the Task Force begin with a caveat regarding the ability to make recommendations in this area being limited by the data and information available to it. The Task Force believes that SSA has a wealth of data available to it that could lead to some benefit awards appropriately being made sooner in the process if it made better use of the data available to it (and which it does not make available to the public). Here are a number of examples of data that we are not aware of being used to inform policymaking that could be:

- **Data from prototype states vs. non-prototype states:** Differences in appeals in prototype states vs. states with reconsideration. Based on its nearly two-decade disability prototype experiment, SSA should have data regarding which types of claims get awarded at reconsideration and compare that to what happens in states where those same types of claims go straight to a hearing after the initial denial. For example, are there impairment types where reconsideration is a more effective step than others? Are some impairments most likely to be awarded at reconsideration and if so why?

- **Variance in reconsideration rates:** The award rates at the reconsideration level of appeal vary from a low of 7.9% to a high of 21.3 % at state DDSes and as high as 33.3% at one Federal disability processing unit. What accounts for the huge variation in these percentages. Are there best practices in some states? Is the variation due to different approaches to the collection of medical evidence, for example, or does it have something to do with the way in which cases arrive at these entities?
- **Improving training and policy:** How does SSA use awards made at the reconsideration level to improve training and policy? Does it look for trends in awards based on impairment type to identify the need for changes or clarification in existing policy or training? How are the results of targeted denial reviews utilized to improve initial decisions moving forward?

Ensuring that performance metrics encourage making decisions on the most complete files possible:

The Task Force is aware that SSA must balance a number of different interests when determining how to evaluate the performance of the DDSes. It is our understanding that two primary outcomes are evaluated when determining the performance of DDS adjudicators: how long it takes to issue a decision and how much each decision costs. Although these are important considerations, the completeness of the information on which the decision was based should be factored in to these performance metrics. If a DDS adjudicator is aware of additional medical evidence that could prove the claimant meets (or doesn't meet) a medical listing but does not obtain that evidence and denies the claim (in order to ensure that the decision is made within a certain time period) that harms the claimant and is expensive and inefficient for SSA. A quick denial that could have been an approval but would take more time to process is a bad outcome for all involved. The Task Force does not believe there is a "right amount of time" during which an initial determination should be made. Trying to keep the average processing time to 100 days when doing so results in DDS adjudicators closing claims with outstanding evidence that might lead to a different outcome is counterproductive and inefficient.

Although the Task Force does not have a specific recommendation regarding what performance metrics should be for DDS employees, it is the Task Force position that the completeness of the file upon which the decision is based should somehow be included in those metrics. DDS adjudicators should not have their performance rated lower, for example, for taking longer to process claims to ensure that the medical evidence in the file is more complete and potentially preventing an unnecessary appeal on a claim that could have been approved sooner.

It might be possible to address this by dividing activities completed during the initial decision on a claim into different steps and evaluating the performance in each of those different steps separately. For example, a step could be included in the process entitled "evidentiary development" and ensuring that the procurement of existing medical evidence and requesting additional medical evidence leading to a more complete evidentiary file during this stage could be rewarded through better performance ratings even though it might lead to a slightly longer processing time to do so.

Timeliness of decisions is still very important and must be balanced against the development of the file. It might be helpful to dedicate personnel exclusively to the collection of medical evidence (see discussion below) and transfer the claim to that individual for file development and not count the time it is with that individual against the DDS adjudicator for the evaluation of timeliness of decision made. It is also important to make sure that claims continue to be identified as critical when applicable and as

eligible for quick processing (CAL, QDD) prior to moving a claim into a “evidentiary development (or whatever SSA decides to call this step)” status.

Many of the Task Force recommendations will focus on getting a more complete file early in the process. DDS adjudicators will focus on the aspects of processing claims on which their performance is evaluated. Ensuring that the completeness of the evidentiary record is including in those performance metrics has potential to allow some claims to be decided earlier in the adjudicative process than they currently are saving SSA administrative resources and allowing claimants to get access to vital benefits sooner.

Better case development by the DDS: SSA should make more efforts to obtain medical evidence on behalf of claimants, especially those claimants not represented by professional representatives, at the initial application level. Recent changes to SSA regulations requiring the submission of all medical evidence related to the individual’s impairments was a substantial change from the previous regulations and greatly increased the burden on claimants related to the collection and submission of medical evidence. Many claimants are not able to assist SSA by providing all of this evidence for two primary reasons. First, a claimant’s impairments might make them functionally unable to understand this duty or assist in completing it. Second, medical records can be expensive and many claimants are not in a financial position to pay for their medical records, especially when they are extensive, given this new duty.

SSA regulations specify that the agency has the responsibility to “develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical reports from your own medical sources when you give us permission to request the reports.” The regulations specify that SSA will make two attempts to obtain medical records and will proceed to make a decision without the records if not received after those requests. Claimants representatives routinely report that it takes multiple requests over weeks (and sometimes months) to obtain many medical records and those requests must be “higher touch” (with many calls or visits to medical facilities) than simply sending a written request. In fact, some representatives have hired staff whose entire job is dedicated to obtaining medical records for their clients. The two written requests required by current regulations are insufficient in many cases and cannot be considered “every reasonable effort” given the reality of how difficult it is to obtain medical records. Initial decisions on disability claims are often made without complete medical records as a result.

As discussed above, SSA’s failure to ensure it has all evidence of which it is aware of when the initial decision is made is administratively inefficient and harmful to claimants. The Task Force encourages SSA to implement an initiative to ensure more complete development of medical records at the initial level. There are many ways that SSA can do this, including hiring personnel dedicated to the collection of medical evidence. These individuals could develop relationships with medical records and medical care providers which might facilitate easier collection of medical records. SSA could also have DDSes set aside certain days every month (or one day a week) as medical evidence collection days and exclude those days in processing times for claims.

SSA should also look at the best practices of DDSes regarding the collection of medical evidence. It is quite likely that some agencies do a better job at securing medical evidence than others. SSA should examine and evaluate current practices and then try a variety of ways to improve upon current practices.

Ensuring that treating and other sources and claimants submit evidence most useful to SSA: SSA can take a number of steps to improve the quality of the information included in the evidence it does receive from providers and claimants in support of a claim. The Task Force recommends the following in this area:

- Ensure that questionnaires and forms are understandable to claimants and as free of jargon as possible, as well as appropriately tailored to specific types of impairments and probative of information that addresses the disability standard as implemented by SSA. This “language” barrier can lead to incomplete applications missing key details needed for full development of the claim.
- As with paper records, electronic records need to be adapted to meet the needs of the SSA disability determination process. Many providers submit evidence electronically; these records are based on the providers’ needs but often do not address the SSA disability criteria.
- Provide better explanations to medical providers. SSA and DDS forms and questionnaires should provide better explanations to all providers, in particular to physician and non- physician treating sources, about the disability standard and should ask questions that are probative of evidence and information relevant to the standard. Unclear, hard to understand forms can result in incomplete responses as well as delays in obtaining medical evidence.
- Consider creating impairment specific explanations and forms that claimants can provide to their physician and other treating sources outlining what information is most helpful to SSA in evaluating the claim and including the types of tests which help establish meeting the listing in question.

Claimant Interviews: SSA should provide more assistance to claimants at the application level regarding necessary and important evidence so that all impairments and sources of information are identified, including non-physician and other professional sources. This is especially important for claimants with mental impairments and limited English proficiency. This could be accomplished by the completion of a claimant interview when the claimant is not represented at the initial level.

Improving the feedback loop between the DDS and claimants: When a claimant submits an application for benefits, there is often very little feedback from SSA regarding the content or status of the application. SSA’s role is to accurately determine whether the individual meets the statutory definition of disability and should ensure that it has the information necessary to make that determination. For example, SSA should inform a claimant if there is a test needed for a claimant to be found eligible under a certain listing and that test is not included in the medical records SSA has in the claimant’s file. For example, if a certain kidney listing requires a certain number of blood pressure tests at a certain level within a certain period of time and the claimant’s file has one less blood pressure test than required, SSA should inform the claimant that another blood pressure test is needed to make the decision. If the required test is a test that SSA specifies it will pay for in regulation, it should pay for that test. If regulations specify that SSA will not pay for the test, the claimant should still be made aware that providing the results of that test would be helpful in processing her claim.

Improving Consultative Exams (CE) When Evidence Is Not Available: Steps should be taken to improve the quality of the CE process. There are many reports of inappropriate referrals (e.g., to providers with the wrong specialty given the claimant's condition(s)), short perfunctory examinations, and failure to provide an interpreter for people with limited or no English proficiency during the exam. In addition, there should be more effort to have the treating physician conduct the consultative examination, as authorized by SSA's regulations. SSA should also increase reimbursement rates for providers. To improve provider response to requests for records, appropriate reimbursement rates for medical records and reports need to be established. Appropriate rates should also be paid for CEs and for medical experts who testify at hearings, to ensure availability of qualified medical professionals. Appropriate reimbursement rates would also increase the frequency with which treating physicians agree to conduct CEs at SSA's request, enabling adjudicators to obtain additional medical evidence from a treating source already familiar with the claimant's condition(s) and medical history.

Increased Targeted Denial Reviews: SSA should review more denials of initial claims. TDRs allow SSA's Office of Quality Review (OQR) to examine unfavorable decisions of disability claims issued by state agencies. Fewer than 3 percent of initial level denials receive TDRs; the number performed varies each year based on resources available to the agency. In comparison, Sections 221 (c) and 1633 (e) of the Social Security Act require SSA to review at least half of the favorable decisions issued by state agencies. In Fiscal Year 2016, 7.7 percent of TDRs resulted in a reversal of an unfavorable decision and the issuance of a favorable decision. That reflects nearly 3,400 individuals with disabilities who were spared the need to wait additional months and years to receive critical benefits. Since the program was fully implemented in Fiscal Year 2012, more than 17,000 cases have been kept out of the hearings-level backlog because of TDR. Allowing SSA to use program integrity funding to perform TDRs would increase the efficiency and accuracy of the disability programs. SSA should also ensure that the TDR outcomes are used to improve SSA policy and training for DDS adjudicators by using the data to identify impairments that are being inappropriately denied.

Information About Representation: Representatives play an important role in obtaining medical and other information to support their clients' disability claims and helping SSA to streamline the disability determination process. They routinely explain the process and procedures to their clients with more specificity than SSA can. They obtain evidence from medical sources, other treating professionals, school systems, previous employers, and others who can shed light on the claimant's entitlement to disability benefits. Given the importance of representation, the Social Security Act requires SSA to provide information on options for seeking legal representation, whenever the agency issues a notice of any "adverse determination." This statutorily required information is typically provided only once the claimant has requested a hearing before an ALJ. SSA should provide claimants with more information on options for representation before and during the initial application process.