

Research Portfolio on Social Security's Disability Programs

Medical Evidence Collection in Adult Social Security Disability Claims

Social Security Advisory Board

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Executive Summary

The Social Security Advisory Board (“Board”) has written reports and held public events about the disability determination process throughout its history. Since 2018, the Board has hosted public roundtable discussions with subject matter experts focused on different aspects of initial adjudication. The discussions identified several topics of particular interest, including the collection of medical evidence.¹

This paper examines the process of medical evidence collection for adult disability claimants by the state Disability Determination Services (DDSs).² We discuss the types and sources of evidence used and the technologies supporting evidence collection. We also describe how missing medical evidence affects the disability determination process and how the COVID pandemic has affected medical evidence collection. Lastly, we discuss tradeoffs between lengthy evidence collection and timely claim processing and recommend additional research to improve medical evidence collection and disability determination processes.

¹ Social Security Advisory Board (SSAB), [Summary of Disability Process Improvement Roundtables](#), October 2020 and [Roundtable on Medical Evidence Collection](#), July 29, 2021.

² The Board is focusing on adult examination because children’s claims typically include education records that assist in determining childhood functional limitation but are not necessary for adult disability determinations.

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Acronyms

Acronyms	Term
AMS	Acceptable Medical Source
CDR	Continuing Disability Review
CE	Consultative Examination
DDS	Disability Determination Services
DI	Social Security Disability Insurance
ERE	Electronic Records Express
FY	Fiscal Year
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Information Technology
MDI	Medically Determinable Impairment
MC	Medical Consultant
MER	Medical Evidence of Record
OIG	Office of the Inspector General
POMS	Program Operations Manual System
PC	Psychological Consultant
RFC	Residual Functional Capacity
SGA	Substantial Gainful Activity
SSA	Social Security Administration
SSAB / "Board"	Social Security Advisory Board
SSI	Supplemental Security Income

Introduction

The Social Security Administration (SSA) administers two programs designed to provide income support to individuals with work-limiting disabilities. The Social Security Disability Insurance (DI) program pays monthly benefits to people who meet the statutory definition of disability and have worked long enough to be insured or qualify based on the work and earnings of another eligible person. Supplemental Security Income (SSI) is a means-tested program for people who are elderly, blind, or who meet the disability definition and who also satisfy income and resource limits.

Eligibility for disability benefits is determined based on the following statutory definition:

...inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months...³

To help SSA make that determination, applicants must provide medical evidence to support their claims when they apply for DI/SSI and must list contact information for medical professionals who have treated them.

The Sequential Evaluation Process and Medical Evidence Collection

Social Security has a five-step process for determining disability, known as the sequential evaluation process, depicted in Figure 1.⁴ At step one, SSA field office staff determine whether claimants are earning at or above a threshold defined as substantial gainful activity (SGA)⁵ and meet other technical requirements.⁶ Generally, claim files are transferred from field offices to DDSs following confirmation of eligibility at this step.⁷

³ USC Title 42 [§423\(d\)\(1\)\(A\)](#), 1687 and [§1382c\(a\)\(3\)\(A\)](#), 2293.

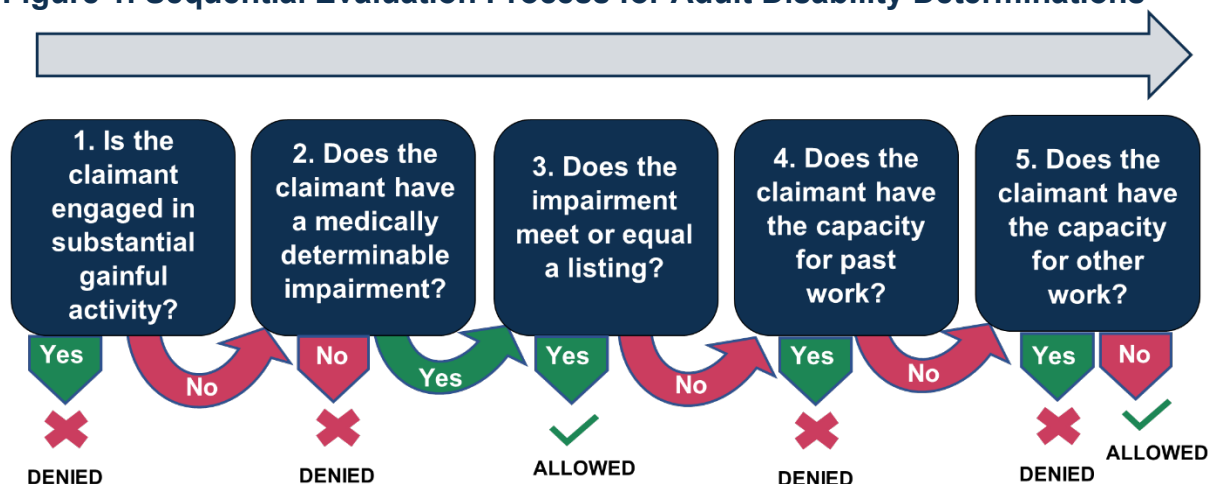
⁴ Title 20 Code of Federal Regulations (CFR), [§404.1520\(a\)\(4\)](#) and [§416.920\(a\)\(4\)](#).

⁵ In 2022, SGA is defined as \$1350 per month for non-blind individuals and \$2260 for those with statutory blindness. SSA, [Substantial Gainful Activity](#), 2022.

⁶ In addition to SGA, step one establishes that the claimant has sufficient covered earnings to be insured for DI (or is insured based on a spouse, former or deceased spouse, or parent's covered earnings), has not reached full retirement age for Social Security retirement benefits and meets residency requirements. 20 CFR [§404.130](#), [§404.330](#) and [§416.202\(b\)](#), absent questions of medical eligibility.

⁷ DDSs operate in each of the 50 states, the District of Columbia and Puerto Rico. Their primary function is to determine medical eligibility for Social Security disability programs. SSA also operates a federal DDS and several disability processing units and disability processing branches around the country. Also, four state extended service teams in Arkansas, Mississippi, Oklahoma and Virginia take overflow claims from other states. These entities assist state DDSs

Figure 1. Sequential Evaluation Process for Adult Disability Determinations



DDSs employ disability examiners, medical consultants (MCs), and psychological consultants (PCs) to conduct disability determinations.⁸ Disability examiners’ responsibilities include developing the case file, preparing it for MC/PC review, evaluating vocational information in the claim, and documenting the determination. MCs/PCs evaluate the medical evidence and the need for further tests or examinations, liaise with the medical community, assess functional capacity, and determine severity and other elements of medical eligibility to complete the remainder of the sequential evaluation process (steps two through five).⁹

At step two, the MC/PC evaluates whether the claimant has a medically determinable impairment (MDI) of sufficient duration and severity to move to step three.¹⁰ At step three, the MC/PC compares the identified MDI (or a combination of multiple MDIs) to SSA’s Listing of Impairments (“listings”) to determine if the MDI (or a combination of qualifying impairments) meets – or equals – the medical and functional guidelines required to award benefits (“allowance”) at this step.¹¹ These documentary guidelines establish the medical and functional evidence the file must contain to trigger an allowance.

when workloads exceed capacity. SSA may suggest case transfers based on its case processing expectations or a state DDS may request a transfer. Regardless of what entity suggests transfer, the state DDS transferring its claims must agree to the arrangement.

⁸ In general, the assignment of a consultant is made based on whether the claim alleges a physical or mental impairment. Both types of consultants are used when both impairment types are asserted. 20 CFR [§404.1615](#), [§416.1015](#), [§404.1616](#) and [§416.1016](#).

⁹ SSA, *Program Operations Manual System (POMS)*, [DI 24501.001\(B\)\(1\), \(3\) and \(4\)](#), 2018.

¹⁰ Durational requirements for non-blind disability claimants can be met before the date of application (or the date the applicant stated their intention to file a claim and established a protective filing date), or after, provided there is evidence of retrospective or likely prospective duration. SSA, *POMS*, [DI 25505.025\(D\)](#), 2015.

¹¹ 20 CFR [§404.1525](#), [§404.1526](#), [§416.925](#) and [§416.926](#).

If, after a review of the available evidence, a claimant's MDI (or multiple MDIs) does not meet or equal a listing, the MC/PC assesses the claimant's residual functional capacity (RFC) to inform steps four and five of the sequential evaluation process. An RFC assessment describes the functions a claimant can perform despite impairment(s). The disability examiner's evaluation at step four considers whether a claimant could continue to perform past work based on an examination of 15 years of the claimant's past relevant SGA-level work. If the claimant is unable to perform their past relevant work, or the evidence is insufficient to evaluate past relevant work, the evaluation moves directly to step five.¹²

The fifth step of the sequential evaluation process considers whether a claimant can perform other work, relying on vocational information such as job requirements, labor market information and a claimant's work history, age, education level, and RFC. The disability examiner determines whether the claimant is unable to continue performing their past work or take up other work and earn at or above the SGA level of earnings. A determination that the claimant can take up other work leads to a denial; if not, the claim is allowed.¹³

The Medical Evidence Collection Process

Records from doctors and other treating sources are referred to as medical evidence of record (MER). In addition to determining step one of the sequential evaluation process, field office staff collect and place MER into an electronic folder along with contact information for the claimant's treating/medical sources (this is an automated process when MER is obtained through a health information technology [HIT] exchange). The folder is updated as subsequent evidence is received. The application might also include a description of the claimant's work history before becoming disabled and current activities of daily living that describe functional capacity. These descriptions often inform the claimant's RFC assessment, referenced earlier.¹⁴

DDS Requests for MER

The disability examiner requests, and the DDS purchases, any MER not received with the initial application from identified treating/medical sources and any additional medical providers the claimant reports seeing for treatment

¹² 20 CFR [§404.1520\(h\)](#) and [§416.920\(h\)](#).

¹³ The disability examiner signs each determination assigned to them. The MC/PC signs all medical evaluation forms, including the RFC, for any claim containing medical evidence. SSA, POMS, DI [26510.090](#), 2015.

¹⁴ SSA, [SSA Form 3373, Function Report – Adult](#), 2020.

during claim development and determination.¹⁵ Generally, a disability examiner is required to collect a 12-month medical history. SSA's regulations require examiners to make "every reasonable effort" to obtain MER, defined as at least two MER requests to a particular provider (or record repository).¹⁶ At a June 2021 Board roundtable, participants told the Board that often several requests over extended periods are needed to ensure MER receipt.¹⁷ While some entities operating outside the Social Security disability process outsource medical evidence collection, DDSs do not.¹⁸ However, SSA is exploring the approach.¹⁹

SSA has created policies and procedures to avoid lengthy evidence collection in limited circumstances. A claim may be allowed even when some MER has not been received. The evidence in the claim file must consistently show a static or progressive severe MDI that has lasted or can be projected to last at least 12 months or result in death.²⁰ This expedited procedure is designed to prevent unnecessary delays and speed workload processing, particularly for claimants with the most severe impairments.²¹

SSA provides funding for the purchase of MER.²² However, each DDS must follow its state's laws and regulations to establish MER payment rates. Some

¹⁵ The disability examiner may contact the claimant (or their appointed representative) during the determination process to gain insight into the impairments alleged and to ensure a complete list of medical sources.

¹⁶ 20 CFR [§404.1512\(b\)](#) and [§416.912\(b\)](#).

¹⁷ SSAB, [Roundtable on Medical Evidence Collection](#), July 29, 2021, 49:35.

¹⁸ In a 2016 survey of 66 claim organizations (insurance and law firms), 25 percent reported using outside record retrieval firms to collect medical and other records. Claims and Litigation Management Advisors, [Current Practices in Records Retrieval](#), Spring 2016, 20.

¹⁹ In January 2022, SSA began a market survey to locate vendors "capable of providing record locator services to identify interactions between a disability claimant and the healthcare system (e.g., physician visits, hospitalizations.)" In the solicitation, SSA stated, "the [current] process relies solely on claimant recall for the names and addresses of medical providers and dates of treatment. As such, the body of medical evidence assembled for evaluation may ... omit information that could be critical in making an accurate determination of disability." SSA, [Request for Information for Record Locator Service 28321322RI0000020](#), January 6, 2022.

²⁰ A fully favorable allowance is one that awards benefits based on the date the claimant alleges their impairment(s) began and is considered the outcome most advantageous to the claimant. SSA, POMS, [DI 24515.020](#), 2021 and [DI 25505.030](#), 2015.

²¹ Other examples of expedited workloads came about during the 2000s when backlogs at all determination levels were increasing, and SSA established additional procedures to fast-track some types of claims. The special procedures were applied to claims alleging impairments of assumed severity and used predictive modeling and other tools to identify them. Examples include Quick Disability Determinations, Compassionate Allowances and Terminal Illness claims. David Raines, ["Fast-Track' Strategies in Long-Term Public Disability Programs Around the World," Social Security Bulletin 72](#), no. 1, February 2012.

²² Purchasing medical evidence is considered an administrative cost and is subject to the Limitation on Administrative Expenses (LAE) applied to non-mandatory SSA spending such as payroll, IT systems and rent. DDS expenses (including medical evidence and other costs) are

DDSs report that they follow Medicare reimbursement rates to pay for records, although others must adhere to state fee schedules.²³ Lower payment rates can slow the receipt of evidence.²⁴

Types and Sources of MER

Not all medical evidence is considered equally in disability determinations. To establish the existence of an MDI or combination of MDIs and proceed past step two of the sequential evaluation process, a claim must include “objective” evidence from an “acceptable medical source” (AMS). Objective evidence includes documented observable “anatomical, physical, or psychological abnormalities” using clinical and laboratory findings.²⁵ AMSs include physicians, psychiatrists, and several other licensed or certified professionals.²⁶

“Treating Physician” Rule Changes

Once an MDI is determined, an MC/PC considers “opinion” evidence -- a treating/medical source’s statement of how or whether a claimant can perform the physical, mental, or sensory demands of work, and medical judgments about diagnosis, severity, or prognosis.²⁷ Regulatory revisions in March 2017 brought a stronger focus on a claimant’s functional capacity. The agency stated its rationale for the shift:

...[d]iagnoses and prognoses [frequent features of treating/medical source opinion] do not describe how an individual functions... A more appropriate focus of medical opinions would be perspectives from medical sources about claimants’ functional abilities and limitations.²⁸

The regulatory revisions require an MC/PC to consider opinion evidence (including that of a medical/treating source) to be “persuasive” only when that source opinion documentation is consistent with the objective evidence in the claim and supportable when considered alongside the rest of the evidence. Specific or controlling weight is no longer given to the claimant’s

the second largest category of LAE spending behind SSA payroll. SSA, [Budget Overview: FY 22 Justification of Estimates for Appropriations Committees](#), May 28, 2021, 5 – 6.

²³ SSA pays a flat rate of \$15 for any HIT record. All other record formats are subject to state payment rates. SSA Office of the Inspector General (OIG), [SSA’s Expansion of HIT to Obtain and Analyze Medical Records for Disability Claims](#), January 3, 2022, Tables A-1 – A-3.

²⁴ SSAB, [State Agencies’ Role in Social Security Disability Determinations](#), September 23, 2021, 0:15:08.

²⁵ 20 CFR [§404.1502\(f\) and \(g\)](#) and [§416.902\(k\) and \(l\)](#).

²⁶ 20 CFR [§404.1502\(a\)](#) and [§416.902\(a\)](#).

²⁷ 20 CFR [§404.1513\(a\)\(2\) and \(3\)](#) and [§416.913\(a\)\(2\) and \(3\)](#).

²⁸ 81 Federal Register (Fed Reg), 62562 (September 9, 2016), [Revisions to Rules Regarding the Evaluation of Medical Evidence: Notice of Proposed Rulemaking](#).

treating/medical sources. Instead, the regulations require the MC/PC to consider factors such as longer treatment relationships and more frequent visits with the claimant as it evaluates opinion evidence. A specialist's opinion may also be considered more persuasive than a source with no specialized training relevant to the impairment.²⁹

SSA no longer recognizes "treating source(s)" in its policy, relying instead on the broader term "medical source(s)."³⁰ Relevant regulations and agency policy reflect this shift. However, this document references treating source(s) to make a clear distinction between those sources who have treated the claimant outside the disability determination context versus consultative sources who are paid by SSA. SSA's policy change makes it difficult to distinguish opinion evidence by source and may inhibit the ability to analyze qualitative differences among the sources informing the determination process.

The 2017 rule also acknowledges challenges in MER collection due to changes in the national health care landscape like those expressed in a 2021 consensus committee report of the National Academies of Sciences, Engineering, and Medicine (NASEM):

Primary care in the United States has changed dramatically in recent decades. The changes have eroded its generalist role and led to the consolidation and reduction in its scope and an erosion of its physician workforce, particularly in rural and underserved areas, coupled with the growth of [nurse practitioners, physician assistants, community health workers], and other health care workers in primary care.³¹

Beyond focusing on function-specific material,³² the treating physician rule change expands the list of AMSs to include non-physician/psychiatrist licensed providers like nurse practitioners, physicians' assistants, and audiologists.³³ However the final rule excludes health professionals trained in functional assessment, such as physical therapists, as AMSs in the expanded list due to licensure variation across states.³⁴

²⁹ 82 Fed Reg 5853 (January 18, 2017), "[Revisions to Rules Regarding the Evaluation of Medical Evidence: Final Rule.](#)"

³⁰ 82 Fed Reg, 5847 [Ibid.](#)

³¹ National Academies of Sciences, Engineering, and Medicine (NASEM), [Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care](#). May 4, 2021, 85; SSAB [supra N. 17](#), 1:49:18.

³² 20 CFR [§404.1513\(a\)\(2\)](#) and [§416.913\(a\)\(2\)](#).

³³ 82 Fed Reg, [supra N. 29](#), 5844.

³⁴ [Ibid](#), 5847.

MER Formats and the Role of Technology in Disability Determination

In addition to the complex types and sources of MER, evidence in a disability claim can also be voluminous.³⁵ Some stakeholders report that the volume of evidence in claim files has increased in part due to duplicative or irrelevant submissions to assure compliance with revised SSA regulations requiring claimants to submit all evidence “related” to their alleged impairment.³⁶ The format of evidence received influences the efficiency (and potentially the policy compliance) of the disability examiner or MC/PC’s work. Records can be shared with SSA or the DDS through an automated data exchange such as HIT, through non-HIT electronic portal uploads (as described in the next section), or by mailing or faxing and scanning paper records.

HIT and Electronic Records Express

For decades, SSA has focused on expanding electronic medical record formats to facilitate rapid collection and review.³⁷ The agency maintains full responsibility for recruiting and onboarding HIT providers as well as funding and supporting the SSA system that queries and receives HIT records.³⁸ As of 2022, the agency had at least one HIT exchange in each state and now counts 211 health system partners. The exchanges include over 31,000 individual health providers.³⁹ However, according to the agency’s Office of the Inspector General (OIG), provider recruitment and SSA staff and contractor resources dedicated to HIT expansion have dropped since 2018, and overall funding for these efforts has been reduced.⁴⁰

Several HIT platforms operate across the country, and SSA has been part of government-wide efforts to develop standards to ensure the usability of evidence.⁴¹ The investments required of medical providers for software and other tools may contribute to DDS-level variation in HIT coverage. For example, in FY 17, the Iowa DDS reported that over 40 percent of its MER was HITMER.⁴² Iowa has two of the largest health systems in the nation, plus the

³⁵ 20 CFR [§404.1512\(a\)](#) and [§416.912\(a\)](#)

³⁶ House Subcommittee on Social Security, “[Testimony of Lisa Ekman, Co-Chair Social Security Task Force Consortium for Citizens with Disabilities](#),” *Examining Changes to Social Security’s Disability Appeals Process*, July 25, 2018, 5.

³⁷ House Committee on Ways and Means, “[Statement of the Honorable Michael J. Astrue, Commissioner of the Social Security Administration](#),” *Eliminating the Social Security Disability Backlog*. March 24, 2009, 19.

³⁸ SSA OIG [supra N. 23](#), 3.

³⁹ SSA, “[Current status \(as of 11/16/20\) – 211 organizations representing 31,231 participating providers](#),” SSA Health IT website.

⁴⁰ OIG [supra N. 23](#), 14.

⁴¹ [Ibid](#), 8 – 9.

⁴² SSA, [FY 17 DDS CE Oversight Report](#), SSA Freedom of Information Act Reading Room, 82.

Mayo Clinic system in neighboring Minnesota.⁴³ The consolidation of health care delivery may be a factor in increased HIT use.

In contrast, required financial commitments may deter provider uptake of HIT. A 2016 literature review identified several factors that likely slow HIT adoption: smaller providers in rural areas, medical professionals aged 55 and older, and providers operating in low-income communities appeared less likely to participate.⁴⁴ SSA workload data regarding state-by-state HIT use are not publicly available. Public sharing of geographically disaggregated data would be helpful in examining these variations.

HITMER records generate efficiencies unavailable in other formats. For example, SSA systems automatically compare treating/medical sources listed in a claimant's application to identify HITMER providers upon receipt. Participating sources are then queried for records once a patient-provider match is confirmed, and the claimant's medical authorization is accepted. MER then populates the electronic claim folder, sometimes even before the claim transfers from the SSA field office to the DDS.⁴⁵

Data-matching issues impede HITMER use, though DDSs, SSA, and medical providers typically resolve them. But HITMER exchanges also can make outreach to the treating/medical sources difficult because of the automated nature of the transaction.⁴⁶ Additionally, image files (such as pulmonary function tests) do not typically transmit via HIT.⁴⁷

In September 2018, SSA reported to Congress that claims with some HITMER were processed 10 percent faster than claims without any.⁴⁸ Still, the more frequently used electronic format is Electronic Records Express (ERE), an online portal where participating sources manually upload health records to the electronic folder. Although it is not an automated data exchange system, ERE records are viewable across SSA and DDS systems, and software tools can enhance search and other document review features. Medical sources are encouraged to upload requested materials directly to ERE when possible. Paper

⁴³ Becker's Hospital Review, "[100 of the largest hospitals and health systems in America](#)," December 22, 2020; Unity Point Health, "[UnityPoint Health Named 2017 Most Wired Advanced](#)," July 10, 2017.

⁴⁴ C.S. Kruse et al, "[Barriers to Electronic Health Record Adoption: a Systematic Literature Review](#)," *Journal of Medical Systems*, October 6, 2016, 252; Imam M. Xierali, et al. "[Factors influencing family physician adoption of electronic health records](#)," *Journal of the American Board of Family Medicine* 26, no. 4, July 2013, 390.

⁴⁵ SSAB, [supra N. 17](#), 23:27.

⁴⁶ [Ibid](#), 25:47.

⁴⁷ [Ibid](#), 29:57.

⁴⁸ House Subcommittee on Social Security, "[Post-Hearing Questions for the Record Submitted to Patricia Jonas Deputy Commissioner Office of Analytics, Review, and Oversight SSA From Representative John B. Larson](#)," *Hearing on Examining Changes to Social Security's Disability Appeals Process*. July 25, 2018, 4.

records mailed from claimants or treating sources are the least efficient evidentiary format because they require manual scanning and uploading.⁴⁹ In FY 19, 51.6 percent of MER received was electronic (either ERE or HIT), up from 37.1 percent in FY 16. In FY 21, 11.7 percent of all MER received was HITMER.⁵⁰

Facilitating Medical Evidence Collection at the DDS – the Medical Professional Relations Officer

Management of a DDS’s relationship with the medical community is complex and requires a type of outreach somewhat unique within each state agency.⁵¹ Each DDS has one or a team of medical professional relations officers who are tasked to build relationships with medical/psychological providers in the state or community and are responsible for:

- Recruiting and overseeing qualified medical professionals to serve as consultative sources or MCs/PCs for the DDS
- Conducting outreach to medical and other sources to train them on Social Security evidentiary requirements and how those sources can provide evidence relevant to the disability determination process
- Managing the state DDS ERE portal and vendor file that lists medical sources⁵²

Machine Learning at the Initial Level

Given the volume of records associated with disability claims, locating relevant content within a file is paramount to an efficient process. Records provided as images (such as portable document formats) instead of text-based files or as free text (such as physician notes) can make automated searches for specific information more difficult.⁵³ Software tools that read image-based or scanned

⁴⁹ The electronic folder is accessible to both SSA and the DDS. In September 2020, SSA granted viewable access to the medical evidence portion to some appointed claimant representatives. SSAB [supra N. 17](#), 29:01 and SSA, “[Important Update for Appointed Representatives](#),” *Information for Groups and Organizations*, September 24, 2020.

⁵⁰ Data provided by SSA via email to the Board staff (documentation available from SSAB), January, 18, 2022.

⁵¹ DDS examiners and MC/PCs rarely meet claimants face-to-face, unlike the staff at SSA field offices. Jacqueline Kauff, Jonathan Brown et al, “[The Policy Context](#),” *Findings from a Study of the SOAR Initiative*, Mathematica Policy Research, Inc., December 14, 2009.

⁵² SSA, “[Professional/Medical Relations Officers In Your Area](#),” *Medical/Professional Relations* website.

⁵³ Seyedmostafa Sheikhalishahi, Riccardo Miotto, et al, “[Natural Language Processing of Clinical Notes on Chronic Diseases: Systematic Review](#),” *JMIR Medical Informatics* 2019;7(2):e12239, 2 and Kasper Jensen, Cristina Soguero-Ruiz et al, “[Analysis of free text in electronic health records for identification of cancer patient trajectories](#),” *Scientific Reports*, April 7, 2017, 7.

records and programs such as natural language processing⁵⁴ adopted by SSA in the 2010s have enhanced case processing speed at the hearings level.⁵⁵ Machine learning tools identify relevant elements of medical evidence that the disability examiner and MC/PC can evaluate (and document) as part of the determination.⁵⁶ The deployment of similar tools at the DDS level is currently underway; SSA expects all DDSs to have these applications by the end of FY 22.⁵⁷

Missing MER and Its Effect on the Process

The process described in the previous sections assumes a linear progression from claim receipt to evaluation. However, the evidence collection process is not always so straightforward. Some claims may require additional evidence because the MER supplied is insufficient. New MER may exist from medical treatment received after the claim is filed, or a new impairment allegation might arise while the disability determination process is underway. In these circumstances, a disability examiner must investigate any new allegation as part of the sequential evaluation process by collecting new related MER.⁵⁸ Such additional developments add time to an already lengthy adjudication process.⁵⁹

These circumstances might lead to a feedback loop as the disability examiner seeks additional information to process a disability claim using one (or more) of the following steps represented in Figure 2: ⁶⁰

- Contact the claimant to determine if there are new sources or records to obtain or if there are changes to the impairment (or new impairments) that may affect eligibility
- Contact existing medical sources for updated, more complete or more relevant records, such as functional information
- Order a consultative examination (CE) to fill in gaps in the MER and help to document the determination

⁵⁴ Natural language processing is a form of artificial intelligence that allows a computer to read and understand language the way humans can, including author intent. IBM, [“Natural Language Processing.” IBM Cloud Learn Hub.](#)

⁵⁵ David Freeman Engstrom, Daniel E. Ho, Catherine M. Sharkey and Mariano-Florentino Cuéllar, [Government by Algorithm: Artificial Intelligence in Federal Administrative Agencies](#), February 2020, 40.

⁵⁶ OIG [supra N. 23](#), 13.

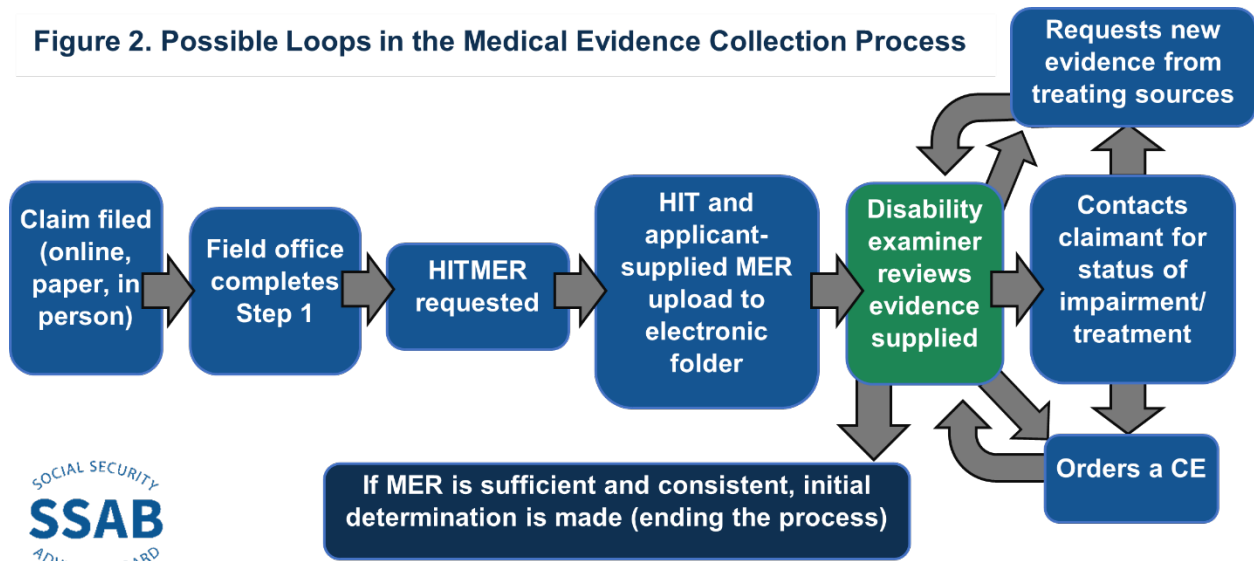
⁵⁷ SSA, [FY 22 Justification of Estimates for Appropriations Committees](#), May 28, 2021, 174; agency comments on this report that are on file at the Social Security Advisory Board.

⁵⁸ 20 CFR [§404.1512\(b\)\(i\)](#) and [§416.912\(b\)\(i\)](#).

⁵⁹ Later in this paper, the Board advocates for a publicly available empirical analysis of this phenomenon and any related delays in time to decision.

⁶⁰

Figure 2. Possible Loops in the Medical Evidence Collection Process



Missing MER and the CE

Even after obtaining missing source evidence, a claimant’s MER may be found to be incomplete or inconsistent, and the disability examiner and the MC/PC may decide they cannot determine disability without additional information. In these instances, the disability examiner may order a CE according to the individual DDS business process.⁶¹ A CE is an examination conducted by a medical source chosen by the DDS and paid for by SSA.⁶² The disability examiner informs the consultative source of relevant health background and needed areas of assessment.⁶³ The DDS schedules the CE and the consultative source carries out the CE and then submits a report for consideration during claim processing.

Reliance on CEs varies widely across DDSs. For example, in FY 19 the CE rate for Puerto Rico was 66.1 percent, while the District of Columbia’s was 16.1

⁶¹ Individual DDS business processes may include an approval mechanism for ordering the CE, such as supervisory sign-off or claimant contact indicating no new medical treatment. However, DDSs are not required to establish an approval mechanism except if the CE would put the claimant at risk. USC 42 §421(j), 1678; SSA, POMS, [DI 22510.001\(B\)](#), 2013 and SSAB, [Summary of Disability Process Improvement Roundtables](#), October 2020, 9.

⁶² A consultative source is not required to be an AMS unless the CE is needed to establish an MDI. Also, consultative sources can be fee-for-service providers or contractors for all CEs at a DDS. For example, the Pennsylvania DDS has a single source contract for conduct of all agency CEs. 20 CFR §404.1517 and §416.917; SSA, POMS, [DI 22510.010](#), 2017; SSAB [supra N. 17](#), 1:20:07.

⁶³ SSA, POMS, [DI 22510.017](#), 2020

percent.⁶⁴ The lowest CE rate is the federally operated DDS at 2.3 percent.⁶⁵ There is no publicly available study of this variation. Later in this report, the Board outlines a recommendation to examine the effects of this variation on disability adjudication.

Controversy and Challenges

In cases with limited evidence, CEs may be obtained to adjudicate a claim; they are a controversial aspect of the disability determination process. Some Members of Congress and others describe CEs as cursory examinations that yield reports of little evidentiary value.⁶⁶ The only publicly available quantitative analysis of CE quality focused on whether individual CE reports included the required documentation. It did not measure the examinations' completeness and their effect on decisional accuracy.⁶⁷ In November 2021, the Government Accountability Office reported concerns about the qualifications and training of state agency consultants determining disability.⁶⁸ An analogous review of state consultative examiners would help assess the merit of these concerns.

Some claimants' representatives and others argue that DDSs' reliance on CEs is misplaced and that DDSs should encourage disability examiners to spend more time helping claimants develop MER.⁶⁹ Claimant representatives also advise clients to avoid the need for a CE by requesting that treating/medical sources fill identified evidentiary gaps.⁷⁰ Representatives and other stakeholders also encourage SSA to revisit its treating source policy on CEs.⁷¹ However, the DDSs must balance claim development time and resources with SSA's established performance measures. This balance may be harder to achieve if DDSs are required to devote more time to medical evidence collection.

SSA regulations allow a medical professional who treats a claimant to serve as a consultative source for a CE. In fact, a preference for a claimant's treating

⁶⁴ SSA, [FY 21 Justification of Estimates for Appropriations Committees](#), February 10, 2020, 123 – 125.

⁶⁵ SSA defines its CE rate as the total number of CEs ordered and paid for compared to the total number of cases. See "Table 3.6 FY 19 CE Counts and Cost Data, Note 3," [Ibid](#), 123.

⁶⁶ Senate Permanent Subcommittee on Investigations, [Minority Staff Report: Social Security Disability Programs: Improving the Quality of Benefit Award Decisions](#), September 13, 2012, 4.

⁶⁷ David Wittenburg, et al., [An Assessment of Consultative Examination \(CE\) Processes, Content, and Quality: Findings from the CE Review Data, Final Report](#), *Mathematica Policy Research*, November 4, 2012, xii – xiii.

⁶⁸ Government Accountability Office, [Actions Needed by SSA to Ensure Disability MCs Are Properly Screened and Trained](#), November 9, 2021.

⁶⁹ Subcommittee on Social Security [supra N. 36](#), 7.

⁷⁰ SSI/SSDI Outreach, Access and Recovery (SOAR), "[Consultative Exams: A DDS Option to Gather Additional Information](#)" website and Clifford Michael Farrell, Esq., "[Attacking the SSA Consultative Examination](#)," *Avvo Legal Guide*, November 5, 2011.

⁷¹ Subcommittee on Social Security [supra N. 36](#), 7.

source to conduct a CE has existed in SSA regulation for 30 years. System-wide data on the number of treating source CEs are unavailable. However, at the Board's roundtable on medical evidence, participants reported that treating source CEs are rare.⁷² In a 2012 SSA-commissioned study, none of the 327 examinations in the sample were conducted by the treating source.⁷³ Reasons for this phenomenon might include:

- An ethical dilemma for treating sources who want to avoid conflating roles as an assessor for SSA with the clinical obligations to the patient⁷⁴
- DDS letters and forms that do not highlight or otherwise make clear requests for treating sources to perform the CE⁷⁵
- A need on the part of DDSs to assign CEs to recruited sources to incentivize those sources' continued participation in the program. Lower payment rates for CEs can be partially overcome by referring multiple claimants for examination⁷⁶

A NASEM review of the disability determination process from 2007 identified CE payment rates as another deterrent to the claimant's treating/medical source's participation.⁷⁷ According to DDS CE oversight reports published by SSA, amounts paid for CEs are low compared to fees paid by other users of such assessments. The fee disparities complicate recruitment and retention of consultative sources, especially specialists.⁷⁸ NASEM reported similar findings.⁷⁹

Virtual CEs

One idea to combat geographic disparities in medical expertise and expand the pool of consultative sources is to create a national cadre of medical and psychiatric specialists recruited, funded, and managed by SSA and available for consultation across the country.⁸⁰ In an October 2020 Board roundtable, researchers discussed virtual CEs and ways to test their efficacy in the disability determination process.⁸¹ A possible model for virtual CEs exists at

⁷² SSAB [supra N. 17](#), 1:23:30.

⁷³ Wittenburg et al [supra N. 66](#), xv.

⁷⁴ American Psychiatric Association, [APA Commentary on Ethics in Practice](#), December 2015, 6.

⁷⁵ New York Legal Assistance Group et al, [Preventing Wasteful and Inequitable Consultative Examinations in Social Security Disability Claims: A Position Paper](#), March 2, 2022, 5.

⁷⁶ SSAB [supra N. 17](#), 1:05:51.

⁷⁷ NASEM, [Improving the Social Security Disability Decision Process](#), 2007, 206.

⁷⁸ SSA [supra N. 42](#), 3, 36, 78, and 125.

⁷⁹ NASEM [supra N. 75](#), 159 – 160.

⁸⁰ The group recommended SSA pilot a national cadre of MC and PC experts to evaluate evidence in SSA disability determinations. However, it did not recommend that CEs be part of the pilot. Bipartisan Policy Center Disability Insurance Working Group, [Improve the SSDI Program and Address the Impending Trust Fund Depletion Consensus Recommendations of BPC's Disability Insurance Working Group](#), August 2015, 17.

⁸¹ SSAB [supra N. 60](#), 21.

the Department of Veterans Affairs, which is expanding its use of virtual/telehealth medicine in ways that SSA might consider.⁸²

DDSs' use of virtual CEs increased during the COVID pandemic after the Department of Health and Human Services relaxed certain Health Insurance Portability and Accountability Act (HIPAA) requirements on telehealth/virtual platforms.⁸³ In response, SSA updated its policy to allow virtual CEs for claimants alleging mental impairment that did not require testing and speech/language evaluations.⁸⁴ During its 2021 roundtable on medical evidence, the Board was told that consultative sources view these virtual CEs favorably.⁸⁵ Research demonstrates that remote examination and assessment of mental and speech/language impairments achieve similar results to in-person examinations, which may be a reason why the agency limited its endorsement of the virtual format to these types of CEs.⁸⁶

The use of virtual CEs requires consideration of internet/broadband access for claimants. According to Pew Research Center data, only 86 percent of very low-income Americans use the internet, compared to 99 percent of more affluent Americans.⁸⁷ The Federal Communications Commission has identified geographic disparities in broadband access as well.⁸⁸

Medical Evidence Collection During the COVID Pandemic

As noted earlier, disability determination hinges on current medical and functional information collected from treating or consultative sources. The pandemic severely curtailed non-essential medical treatment. For example, a June 2020 Centers for Disease Control and Prevention survey found that nearly 41 percent of US adults over age 18 delayed medical treatment during

⁸² The Department of Veterans Affairs (VA) provides a range of platforms from home- to hospital-based remote medicine designed to overcome barriers to care or specialized expertise. They also partner with public and private sector entities to provide secure telehealth locations to veterans without internet access at home. VA, "[Types of Telehealth](#)" and "[Bridging the Digital Divide](#)", VA *Telehealth* website.

⁸³ Office of Civil Rights, Department of Health and Human Services, "[Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency](#)," January 20, 2021.

⁸⁴ SSA, ARCHIVED: [Emergency Message \(EM\) 20015 SEN REV 2, "Scheduling Video Consultative Examinations during the COVID National Public Health Emergency – Revised 2,"](#) September 29, 2020, 2.

⁸⁵ SSAB [supra N. 17](#), 1:18:04.

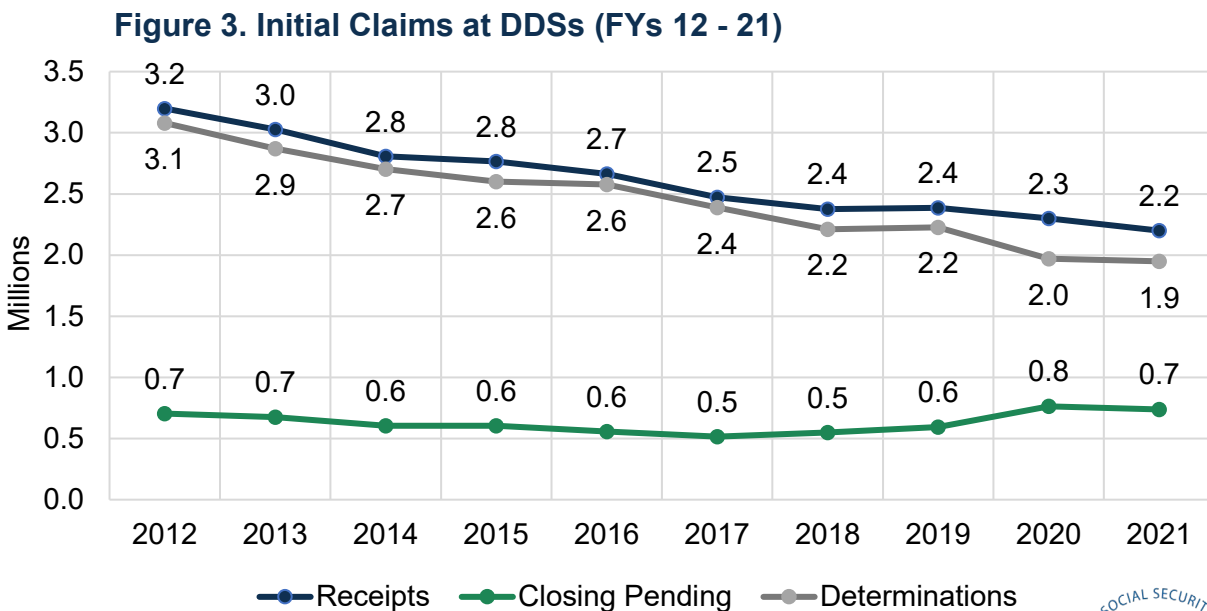
⁸⁶ Substance Abuse and Mental Health Services Administration, [Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders](#), June 2021, 16 and American Speech-Language-Hearing Association, "[Telehealth Evidence Map](#)."

⁸⁷ Pew Research Center, "[Who Uses the Internet](#)," [Internet/Broadband Fact Sheet](#), 2021.

⁸⁸ Congressional Research Service, "[Table 2: Percentage of Americans with Access to Fixed Terrestrial Broadband at Speeds of 25 Mbps/3 Mbps](#)," *The Digital Divide: What Is It, Where Is It, and Federal Assistance Programs*, March 9, 2021, 3.

the pandemic. That percentage was even higher among people with disabilities and those with certain conditions that put them at higher risk for severe COVID infection.⁸⁹ In addition, some medical offices closed in the early days of the pandemic and later reported furloughing staff due to stay-at-home orders and decreased workloads.⁹⁰

Publicly available monthly workload data indicate an increase in the number of initial claims pending at most DDSs in FYs 20 and 21 compared to prior years, even as the number of claims received at those agencies fell (Figure 3).⁹¹ Also, the average processing time for initial DI and SSI disability claims has climbed during the pandemic (Figure 4).⁹² There are likely several factors influencing shifts in workload trends, including access to medical evidence, the ability of DDSs to hire and retain qualified staff, and other issues.



Source: SSA State Agency Monthly Workload Data
Initial Release: January 20, 2010 - last updated October 1, 2021



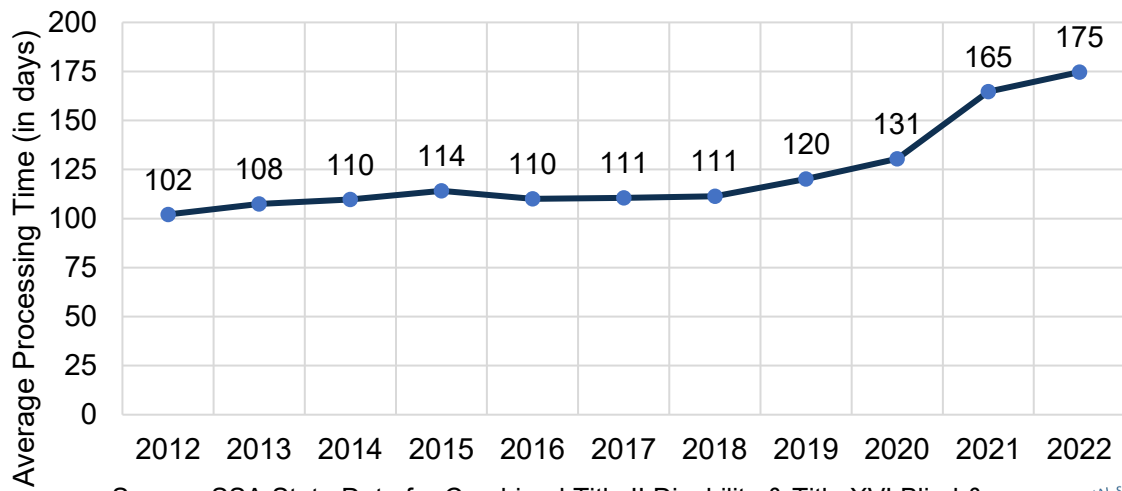
⁸⁹ Mark É. Czeisler; Kristy Marynak, et al, “[Delay or Avoidance of Medical Care Because of COVID-19-Related Concerns](#),” *Morbidity and Mortality Weekly Report*, , September 11, 2020.

⁹⁰ Rita Rubin, “[COVID-19’s Crushing Effects on Medical Practices, Some of Which Might Not Survive](#),” *Journal of the American Medical Association* 324(4), June 18, 2020, 321 – 323.

⁹¹ SSA, [State Monthly Workload](#) dataset, All Initial Claims, Receipts, Closing Pending, and Determinations, October 2012 to September 2021.

⁹² SSA, [Monthly Data for Combined Title II Disability & Title XVI \[SSI\] Blind & Disabled Average Processing Time \(excludes technical denials\)](#) dataset, October 2012 to April 2022.

Figure 4. Combined DI and SSI Disability Processing Time (FYs 12 - 22)



Source: SSA State Data for Combined Title II Disability & Title XVI Blind & Disabled Average Processing Time (excludes technical denials) - last updated April 1, 2022



In its 2021 roundtables, the Board was briefed about multiple challenges and disruptions to DDS productivity since mid-2020, some directly related to health care delivery and medical evidence, others broader and more administrative, including:⁹³

- Conducting remote training for new disability examiners when DDS managers view in-person classes as more effective
- Managing the transition to telework when many DDSs had not received SSA-configured laptops or voice over internet protocol mobile phones before the pandemic
- Ensuring internet access/security for DDS employees working from home
- Documenting a 12-month medical history during the pandemic when fewer patients were visiting the doctor
- Receiving MER from doctors' offices and record repositories when employees who process those requests were furloughed or working remotely
- Scheduling and conducting CEs when SSA required their stoppage for a short time and more claimants declined to attend due to safety concerns⁹⁴

⁹³ SSAB [supra N. 17](#) and [supra N. 24](#), 1:23:00 on.

⁹⁴ The agency's complete CE moratorium lasted from March 17 to May 29, 2020 and was replaced by instructions to resume in-person CEs, consistent with local conditions and government guidelines for non-essential treatment. SSA's FY 20 CE data correspondingly show

- Suspending continuing disability reviews (CDRs) and certain adverse determinations from late March through August 2020

Reviewing Past Determinations – Reconsideration and CDR

Beyond the initial disability determination, the DDS is responsible for conducting two other types of reviews: reconsiderations and medical CDRs. Reconsideration is the first level of review after initial denial. A different disability examiner from the one initially assigned the claim conducts the reconsideration. The second examiner follows the same sequential evaluation process described earlier, including outreach to treating sources requesting new evidence since the initial determination.⁹⁵ Some stakeholders report that reconsideration does not typically involve new MER or new impairments and leads to a relatively small percentage of claims being allowed at that stage of review.⁹⁶

A CDR is a review conducted by the DDS to ensure continued medical eligibility for disability benefits. The disability examiner conducting the medical CDR follows an eight-step process, which is different from the initial determination. The CDR focuses on determining if there is any improvement in the medical severity of the MDI(s) that was present at the time of the initial determination or the most recent favorable decision. The DDS also considers new impairment allegations and any treatment or technological innovations that might mitigate the effects of the MDI on work capacity.⁹⁷

The frequency of a CDR depends on the determined impairment(s) and an assigned diary designation.⁹⁸ A predictive model informs the type (and level of review detail) of each CDR.⁹⁹ If a full medical review is required, the beneficiary submits medical evidence accumulated since claim approval (or the last review) and contact information for medical sources. Reviewers use these materials to determine the continuation or cessation of benefits.¹⁰⁰

a 5.8 percent drop in the CE rate across DDSs from FY 19 to 20. SSA, [EM 20023 SEN, “Framework for Resuming In-Person Consultative Examinations,”](#) May 29, 2020, 1; SSA [supra N. 63](#), 123-125.

⁹⁵ This outreach is only required if the claimant reports new sources or new treatments since initial claim development. SSA, *POMS*, [DI 27001.001\(E\)\(2\)](#), 2017.

⁹⁶ Jon C. Dubin, “[Social Security Disability Adjudicative Reform: Ending the Reconsideration Stage of SSDI Adjudication after Sixteen Years of Testing and Enhancing Initial Stage Record Development](#),” *SSDI Solutions*, Committee for a Responsible Federal Budget, 2016, 3-4.

⁹⁷ SSA, *POMS*, [DI 28005.015](#), 2016.

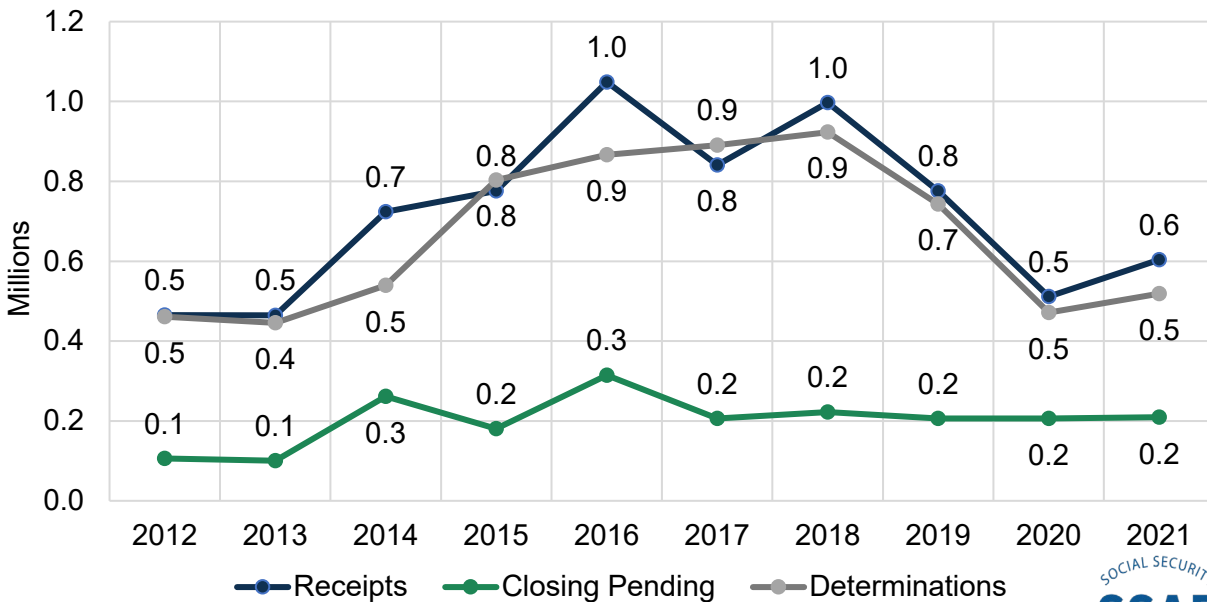
⁹⁸ Diary categories for medical CDRs are medical improvement expected (reviewed every six to 18 months), medical improvement possible (reviewed every three years) and medical improvement not expected (reviewed every five to seven years). 20 CFR [§404.1590](#) and [§416.990](#).

⁹⁹ 84 Fed Reg 63590 (November 18, 2019), “[Rules Regarding the Frequency and Notice of Continuing Disability Reviews—WITHDRAWN](#),” 63590. “

¹⁰⁰ 20 CFR [§404.1593](#) and [§416.993](#).

CDRs were another critical DDS function suspended due to COVID. SSA determined it would not take adverse actions (such as suspending or terminating benefits) at the start of the pandemic; conduct of CDRs resumed in the fall of 2020.¹⁰¹ Figure 5 shows CDR workload processing from FYs 12 to 21.¹⁰²

Figure 5. Continuing Disability Reviews (FYs 12 - 21)



Source: SSA State Agency Monthly Workload Data
Initial Release: January 20, 2010 - last updated October 1, 2021



In April 2021, SSA reported that 30 percent of CDRs require a CE.¹⁰³ Some DDSs say they rely less on CEs for decisions at the initial (and reconsideration) stages but depend more on CEs for CDRs.¹⁰⁴ The reason for this phenomenon is unclear and should be examined further.

The SSA – DDS Partnership

The state/federal approach to disability determination is, at its core, a product of legislative compromise. In the early 1950s as policymakers debated creating

¹⁰¹ SSA, [EM 20019 SEN Rev 3, “Disability Determinations Services \(DDS\) Procedures - Coronavirus Disease 2019 \(COVID-19\) Crisis,”](#) November 18, 2020, 2 – 3.

¹⁰² SSA, [State Monthly Workload](#) dataset, All Reconsiderations, October 2012 to September 2021.

¹⁰³ Senate Committee on Finance, [“Testimony of Grace Kim, Deputy Commissioner for Operations,”](#) *Social Security During COVID: How the Pandemic Hampered Access to Benefits and Strategies for Improving Service Delivery*, April 29, 2021, 9.

¹⁰⁴ One example is the Commonwealth of Virginia, according to DDS management there.

a federal disability insurance program, some expressed concern it would lead to a federalized health care system. To address this concern and ensure access to local medical professionals, determining medical eligibility for disability became the province of states. Since the states administered vocational rehabilitation and worker's compensation programs, they were considered well-suited for determining medical eligibility for Social Security disability.¹⁰⁵

SSA funds the state DDSs; however, DDSs are state agencies, and their workforces are comprised of state employees. Each DDS also operates according to the rules of its state parent agency. For example, when determining disability, a DDS follows regulations and policies promulgated by SSA and is subject to federal quality reviews.¹⁰⁶ Each DDS determines its own qualifications for hiring disability examiners and must comply with state rules for hiring and certain state fiscal requirements and audits. DDSs recruit locally, oversee medical sources, facilitate evidence collection, and order CEs. However, 52 separate state-run entities can lead, unsurprisingly, to variation in performance and outcomes.¹⁰⁷

Quality Review and Medical Evidence Collection

A disability determination may be subject to review within the DDS, at an SSA regional office or through one of three review types conducted at the national level. The manner of DDS quality review is largely at the discretion of the DDS, so long as the internal review is completed before SSA selects cases to examine.¹⁰⁸ The disability quality branches in the SSA regions randomly select cases for review and return cases where the branches find the disability examiner or MC/PC's work to be deficient.

Nationally, SSA administers pre-effectuation, targeted denial, and federal quality reviews. Pre-effectuation reviews occur before payment on an allowed claim. The Social Security Act requires the examination of 50 percent of all initial disability allowances before payment as a program integrity step.¹⁰⁹ Available resources and a predictive model set the annual number of denied claims studied as targeted denial reviews. In addition, SSA's Office of Quality Review (OQR) randomly reviews 70 allowed and 70 denied claims per DDS each

¹⁰⁵ John R. Kearney, "[Social Security and the 'D' in OASDI: The History of a Federal Program Insuring Earners Against Disability](#)," *Social Security Bulletin* 66, no. 3, 2005/2006.

¹⁰⁶ SSA regulates its administrative relationship with DDSs, outlining responsibilities of each and setting expectations for DDSs such as staff training, timeliness, and accuracy of determinations. 20 CFR [Part 404 Subpart Q](#) and [Part 416 Subpart J](#).

¹⁰⁷ Jack Smalligan and Chantel Boyens, [Improving the Social Security Disability Determination Process](#), Urban Institute, July, 2019, 7 – 8 and SSAB, [Disability Chartbook: Chapter 7 Variation in DDS Decision Making](#), 2017.

¹⁰⁸ SSA, *POMS*, [DI 39515.001](#), 1990.

¹⁰⁹ USC 42 [§421\(c\)\(3\)](#), 1676.

quarter. SSA uses the results of these random federal quality reviews to establish SSA's decisional accuracy rates.¹¹⁰

OQR reviewers may return claims to adjudicating DDSs based on deficiencies such as insufficient medical evidence/documentation of impairment severity or duration. Non-substantive corrective actions that would not affect the outcome of a claim (such as an incomplete medical history when sufficient documentation exists to support the initial determination) may also be subject to return.¹¹¹ Quality reviews examine evidence collection to assess whether the necessary evidence is present (or whether attempts to obtain the needed evidence were documented) in the claim file and whether the evidence supports the determination.¹¹²

Productivity, Performance Goals, and Medical Evidence Collection

Each state agency must seek the medical evidence needed for every claim and adhere to SSA's requirements for timely and cost-effective decision-making.¹¹³ Meanwhile, SSA's funding allocations to operate DDSs and to purchase evidence are influenced by the federal appropriation process and competing priorities within the agency.¹¹⁴ The balance between timely decision-making and thorough medical evidence collection is further codified through SSA policies that discourage protracted searches for evidence beyond what the law and regulations require.¹¹⁵

Suggested Research on Medical Evidence Collection

Through its study of medical evidence collection, the Board identified several areas for further examination. Well-designed research projects could study outcome variation by treating source, evidence type, and collection/evaluation processes used. This section outlines the Board's recommendations for examples of research questions that should be studied.

¹¹⁰ SSA, "[Annual Data for DDS Accuracy main page](#)," *Open Government Initiative* website.

¹¹¹ SSA, *POMS*, [DI 30005.232](#), 2020.

¹¹² SSA's current definition of an "accurate" decision (one that is deemed consistent with agency policy and with similar claims) would, in specific research environments, indicate a standard of reliability rather than one of accuracy. SSA, *POMS*, [DI 30005.001](#), 2011.

¹¹³ 20 CFR [§404.1641](#), [§404.1642](#), [§404.1643](#), [§416.1041](#), [§404.1042](#) and [§416.1043](#).

¹¹⁴ SSA, [Commissioner Saul Communicates to Congress about the State of Social Security Services](#) April 26, 2021; Smalligan and Boyens [supra N. 94](#), 14 – 15.

¹¹⁵ SSA, *POMS*, [DI 22505.001\(A\)\(2\)](#), 2020.

Examining the Tradeoffs of More Thorough Documentation vs. Timely Initial Decisions

Experts who advocate changes to the determination process mostly agree that well-documented claims at the initial level are ideal for determining Social Security disability.¹¹⁶ However, DDSs are consistently challenged to balance the requirements of developing MER with meeting established processing time and productivity goals within funding constraints.¹¹⁷ Some observers suggest devoting more time and funding for medical evidence collection at the reconsideration level to test more rigorous claim development.¹¹⁸ Others propose the elimination of reconsideration and the reallocation of those resources back to the initial stage to offset the cost of a more robust initial determination process.¹¹⁹ In the early 2000s, SSA planned to test the effects of investments in initial determination process improvements on key workload metrics, only to abandon the effort when backlogs formed at the hearings level and resources became scarce.¹²⁰

The Board encourages Congress and SSA to consider funding short-term, targeted research to test DDS-level process and policy changes alongside rigorous evaluative schemes. The research could study how the following characteristics affect DDS performance and workload measures, such as accuracy rate, average processing time, production per work year and pending cases.¹²¹

- MER characteristics: value, availability, quality, and volume
 - Expanding the definition of “every reasonable effort” to accommodate a more intensive initial search for MER
 - Identifying variation in the volume, types and sources of available MER by geographic location, demographic and socioeconomic characteristics, as well as other variables
 - Studying how much MER is duplicative and/or irrelevant, the extent to which these issues affect the ability of adjudicators to

¹¹⁶ Harold J. Krent, “[Compression and Rationalization: Demarcating the Roles of DDS and ALJs in the Disability Determination Process](#),” *SSDI Solutions*, Committee for a Responsible Federal Budget, March, 2019, 9 and Consortium for Citizens with Disabilities, “[Improving Decision Making at the Disability Determination Services](#),” March 6, 2019, 2 – 3.

¹¹⁷ Administrative Conference of the United States, “[Recommendation 2021-10: Quality Assurance Systems in Agency Adjudication](#),” December 16, 2021, 2.

¹¹⁸ Smalligan and Boyens [supra N. 105](#), 25.

¹¹⁹ Dubin [supra N. 94](#), 10-12.

¹²⁰ Smalligan and Boyens [supra N. 105](#), 12.

¹²¹ Production per work year is SSA’s measurement of productivity per employee per year. It divides productive hours (hours not on leave or weekends) by the number of claims processed. SSA, *POMS*, [DI 39503.230](#), 1996.

- locate relevant material in the file and the effect of machine learning on identifying the necessary material
- Incentivizing provider participation in SSA-sponsored HIT initiatives
- Establishing a “community of practice” to share demonstrably effective DDS-level MER collection techniques, such as treating/medical source questionnaires
- Examining how adjudicators consider alternative evidence sources in determining medical eligibility, including:
 - Objective medical evidence
 - Medical source opinions
 - Claimant and other source statements
 - Decisions by other governmental/nongovernmental agencies
 - SSA’s own experts
- CE characteristics: quality, incentives, prevalence, and policy compliance
 - Assessing the potential benefits and limitations of standardizing the DDS business process for CEs
 - Understanding the causes of state/regional differences in CE use
 - Determining any relationship between state hiring practices or payment rates, and the effects of payment variations on MER collection efficiency
 - Establishing more robust qualifications of consultative sources
 - Measuring the effectiveness of contingency plans when CEs are difficult to obtain (i.e., during the pandemic period)
 - Assessing the overall quality of the evidence obtained via CEs
 - Quantifying the delays and other effects of the “loops” described in Figure 2

Each of these characteristics is an important feature of the initial determination, yet few publicly available quantitative analyses exist to demonstrate their value to timely, accurate decision-making. Periodic studies should examine the effect of these factors on case progressions through all adjudicative stages. Time to decision, accuracy and other studies could illuminate the costs and benefits of early claim development and evidence collection versus error correction at the hearings level and beyond.

Assessing Policy on Treating/Medical Source CEs

SSA policy states that a claimant’s treating/medical source is the preferred consultative source to conduct a CE. Both anecdotal information and a quantitative analysis commissioned by SSA indicate that treating source CEs are rare despite this explicit preference. SSA should examine why treating

sources do not provide CEs and evaluate alternative policies to achieve a higher rate of CE completion by the claimant’s own treating/medical sources.

Determining Sources of Habitual Delay and Noncompliance with MER Requests and Encouraging Timely Submission

Some providers may be known to the DDS as unlikely to provide MER when requested.¹²² Considering this, SSA should use its data analytic capability to look across states and regions to identify the medical record repositories or provider networks representing the largest share of incomplete MER due to ignored requests. Surveys of those entities could identify the reasons for non-compliance. A pilot project could examine strategies to improve evidence collection frequencies from these sources.

Conclusion

Under the current disability determination process, medical evidence collection is necessary to inform the disability decision. However, regulations designed to improve decision-making may complicate adjudication as claim files expand and include more duplicative and irrelevant evidence. SSA should continue to invest in automated methods (such as HIT and machine learning applications) that speed the collection and evaluation of evidence. Policymakers should also consider research projects to assess the effects of a longer and more proactive period of claim development (when necessary) on both administrative and disability program costs.

The Board encourages SSA, DDSs, extramural researchers, advocates, and policymakers to examine the medical evidence collection process closely. These examinations should include, but not be limited to:

- The effect of evidence collection on program outcomes
- Claimant and DDS-level variation in the availability of different types of evidence
- The effectiveness of automated processes for collecting and evaluating evidence
- Ways claimant treating/medical sources can be better engaged in the disability determination process

SSA has committed to focus on improving the customer experience for those interacting with the agency.¹²³ This focus could inform medical evidence collection, provided that SSA identifies claimants, taxpayers, medical providers, and SSA/DDS employees and consultants as customers in that context.

¹²² SSA, POMS, [DI 22505.008\(C\)\(1\)\(a\)](#), 2016.

¹²³ SSA, “[Superior Customer Experience](#),” *Vision 2025* website.

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