

# The Importance of Specialist Medical Consultants in the SSA Disability Determination Process: Analysis and Proposals

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*ABSTRACT: This Note examines the use of medical experts in the disability determination process for the Social Security Agency’s (“SSA”) two primary disability programs: Social Security Disability Insurance (“SSDI”) and Supplement Security Income (“SSI”). Specifically, this Note focuses on the use of medical consultants at the initial disability determination level and considers how the lack of medical specialty among these consultants contributes to the inconsistencies among state Disability Determination Services (“DDSs”) and Administrative Law Judges (“ALJs”). As a result, this Note argues that the medical consultants used at the initial disability determination process lack the necessary, specialized medical knowledge to adequately and quickly process the increasing number of SSI and SSDI applications each year. Because these medical consultants are extremely important in the initial disability determination phase, the SSA should make specific efforts to train the consultants already employed by the DDSs in particular medical areas and should make medical experts more readily available at the DDS and ALJ levels of review. Alternatively, this Note proposes that the SSA should collect and analyze its data regarding medical consultants and should update its regulations to require DDSs and ALJs to better explain their use of medical experts in their disability opinions so that the issue can be better observed and recorded.*

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## I. INTRODUCTION

The Social Security Administration (“SSA”)<sup>1</sup> is both one of the largest governmental agencies in the United States,<sup>2</sup> and also one of the most economically and administratively dysfunctional.<sup>3</sup> Although some of the SSA’s

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1. When I refer to the SSA throughout this Note, I am referring to the federal governmental body that administers both Social Security Disability Insurance (“SSDI”) benefits and Supplement Security Income (“SSI”) benefits to disabled Americans.

2. In 2015, “65.1 million people received benefits from” an SSA-administered program. SOC. SEC. ADMIN., PUB. NO. 13-11785, FAST FACTS & FIGURES ABOUT SOCIAL SECURITY, 2016, at ii (2016), [https://www.ssa.gov/policy/docs/chartbooks/fast\\_facts/2016/fast\\_facts16.pdf](https://www.ssa.gov/policy/docs/chartbooks/fast_facts/2016/fast_facts16.pdf).

3. 166 million people contributed to Social Security in 2014. See Drew DeSilver, 5 *Facts About Social Security*, PEW RES. CTR.: FACT TANK (Aug. 18, 2015), <http://www.pewresearch.org/fact-tank/2015/08/18/5-facts-about-social-security>. Regardless of this large support, it is estimated that by 2016, the Disability Insurance Trust Fund Reserves (which provides for SSDI benefits) will be depleted, “at which time continuing income to the DI Trust Fund would be sufficient to pay 80 percent of DI benefits.” THE BD. OF TRS., FED. OLD-AGE & SURVIVORS INS. & FED. DISABILITY INS. TR. FUNDS, THE 2013 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL OLD-AGE AND SURVIVORS INSURANCE AND FEDERAL DISABILITY INSURANCE TRUST FUNDS 1, 2, 4, 22 (2013), <https://www.ssa.gov/oact/tr/2013/tr2013.pdf>. Additionally, Social Security’s cost exceeded both its tax income and its non-interest income in 2013, which it has done since 2010. *Id.* at 3. This trend is expected to continue through

more conspicuous failings have been well documented and adequately criticized—such as the enormous backlog of cases or the astronomical Administrative Law Judge (“ALJ”) disability allowance rate<sup>4</sup>—in 2014, the number of individuals receiving Social Security Disability Insurance (“SSDI”) benefits<sup>5</sup> and Supplemental Security Income (“SSI”) benefits<sup>6</sup> was higher than ever. Additionally, new SSDI recipients received higher monthly payments than those individuals already receiving benefits.<sup>7</sup>

In recognition of what appears to be the nadir of the SSA’s public standing among taxpayers, Congress, disability claimants, and the general public, this Note considers a smaller-scale issue arising under the SSA regulations: the specialty (or lack thereof) of medical consultants (“MCs”), primarily at the preliminary Disability Determination Services (“DDS”) level. By principally examining the beginning of the SSA disability process, rather than the later and more politically charged ALJ hearing process, this Note illustrates the inherent problems with having non-specialized MCs performing what can often become medically sophisticated disability determinations. Specifically, the lack of specialized MCs seriously diminishes the public’s trust in the accuracy of the disability determination process, while also creating unacceptable disparities in determination decisions across the country so that a person’s chance of receiving benefits largely depends on where they live. This Note demonstrates that requiring DDS MCs to be specialists in the area of the claimant’s impairment will have positive, far-

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2022. *Id.* As for SSI benefits, it is “project[ed] that SSI program outlays will increase to \$60.8 billion in 2039, a real increase of 0.5 percent per year” and that “[b]ecause DI and OASI benefit receipt affect SSI program eligibility and payment amounts, trust fund reserve depletion has the potential to increase cost for the SSI program.” SOC. SEC. ADMIN., ANNUAL REPORT OF THE SUPPLEMENTAL SECURITY INCOME PROGRAM 6, 27 (2015), <https://www.ssa.gov/oact/ssir/SSI15/ssi2015.pdf>.

4. See, e.g., PERMANENT SUBCOMM. ON INVESTIGATIONS, U.S. SENATE, SOCIAL SECURITY DISABILITY PROGRAMS: IMPROVING THE QUALITY OF BENEFIT AWARD DECISIONS 14, 14 n.32 (2012), <https://www.hsgac.senate.gov/download/report-psi-minority-staff-report-social-security-disability-programs-improving-the-quality-of-benefit-award-decisions> (noting that in a 2011 review, the SSA found that 22% of the hearing decisions had to be remanded for inaccuracy); Richard J. Pierce, Jr., *What Should We Do About Social Security Disability Appeals?*, 34 REG., no. 3, 2011, at 39 (arguing that the ALJs for the SSA should be eliminated because they consistently grant far too many SSA disability claims on appeal and cost the SSA upwards of \$2 billion per year in unnecessary salaries); David Fahrenthold, *The Biggest Backlog in the Federal Government*, WASH. POST (Oct. 18, 2014), <http://www.washingtonpost.com/sf/national/2014/10/18/the-biggest-backlog-in-the-federal-government> (detailing how the ALJ hearing office is 990,399 cases behind).

5. In December 2014, 10,261,268 individuals received SSDI benefits. SOC. SEC. ADMIN., PUB. NO. 13-11826, ANNUAL STATISTICAL REPORT ON THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM, 2014, at 11 chart 1 (2015), [https://www.ssa.gov/policy/docs/statcomps/di\\_asr/2014/di\\_asr14.pdf](https://www.ssa.gov/policy/docs/statcomps/di_asr/2014/di_asr14.pdf).

6. In January 2016, 8.3 million individuals received SSI benefits averaging \$542 per month. U.S. SOC. SEC. ADMIN., ANNUAL REPORT OF THE SUPPLEMENTAL SECURITY INCOME PROGRAM 2 (2016), <https://www.ssa.gov/oact/ssir/SSI16/ssi2016.pdf>.

7. In 2015, the average monthly payment for a newly disabled worker was \$1,270 per month while an individual already receiving SSDI benefits received an average of \$1,166 per month. SOC. SEC. ADMIN., *supra* note 2, at 16.

reaching impacts on the SSA disability determination process, thereby decreasing those disparities and also mitigating against some of the public mistrust that the past few years of mismanagement have created.

Part II of this Note provides background of the SSA and explains how it was created, considers the history behind SSDI and SSI benefits, and briefly explains how a basic SSA disability claim is processed under Title 20 of the Code of Federal Regulations. Part III examines some of the issues inherent in allowing non-specialist MCs to assist in making findings of medical facts for DDSs, including the damage such a policy has on the trust between claimants, taxpayers, and the SSA. Part III additionally considers how the SSA's contemporary push to diminish the backlog of initial disability determination claims and the SSA's 2012 amendment eliminating the need to re-contact a claimant's treating physician are exacerbating the need for MCs to be specially trained in specific medical fields. Part IV provides two suggestions on how the SSA can mitigate against some of the issues this Note raises: (1) creating regional specialists and sub-specialist MCs in each state that correlate with the 12 medical impairments listed on the List of Impairments; and alternatively, (2) having the SSA collect and analyze current information regarding the specialties of MCs, and requiring ALJs and DDS officials to explain in their decisions how they weighed the specialty of the physicians who provide medical opinion evidence. Finally, Part V offers a brief conclusion.

## II. BACKGROUND

In order to fully examine the amplified need for stricter and more specific rules regarding the specialization of MCs, it is first necessary to provide background on the SSA disability process. This Part therefore explains: (1) the history and incentive behind the Social Security Act; (2) the evolution of, and requirements for, SSDI and SSI benefits; (3) the various regulations and steps that SSA officials must follow to make an accurate disability determination under Title 20 of the Code of Federal Regulations; and finally (4) the different medical factors that an ALJ and DDS official must weigh in order to come to a disability determination.

### A. *THE HISTORY AND INCENTIVE BEHIND THE SOCIAL SECURITY ACT*

Today, Social Security and the SSA's administrative sphere includes an enormous, multi-layered system that encompasses various programs and benefits, from special benefits for certain World War II veterans<sup>8</sup> to disability benefits for low-income individuals who have not contributed to the Social Security trust fund.<sup>9</sup> However, when President Franklin D. Roosevelt first

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8. Title VIII of the Social Security Act, 42 U.S.C. § 1002 (2012).

9. Title XVI of the Social Security Act, 42 U.S.C. § 1382.

formalized Social Security<sup>10</sup> by signing the Social Security Act (“the Act”) on August 14, 1935,<sup>11</sup> the scope and intentions of the Act were much less ambitious than they are today.<sup>12</sup>

The main impetus for the Act was an accumulation of various social and economic factors that ultimately compelled the federal government to codify a national pension fund for retired workers.<sup>13</sup> First, as the Industrial Revolution began to gain momentum, people started to move away from rural working environments (where they had largely received economic security from family members as they grew older) to urban working environments (where they had fewer familial or economic options once they entered the workforce).<sup>14</sup> Second, because of the improvements in medical care and general hygiene, people were living longer.<sup>15</sup> Consequently, when the Act was signed in 1935, the elderly population in the United States was the largest it had ever been.<sup>16</sup> The third and interconnected factor that pushed Roosevelt to create Social Security retirement income was the Great Depression. In response to the economic disaster that forced many elderly individuals from the workforce,<sup>17</sup> a large number of individuals began joining various pension plans.<sup>18</sup> These prolific funds promised every contributing individual a certain amount of money each month once the individual retired.<sup>19</sup> In recognition of both the unworkable systems established by those local pension funds, and

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10. For the purposes of this Note, when I state “Social Security” I am referring to the national pension plan for retired workers who have contributed to the Social Security trust fund throughout their employment. See Larry DeWitt, *The Development of Social Security in America*, 70 SOC. SECURITY BULL., no. 3, 2010, at 1–2 (“Social insurance provides a method for addressing the problem of economic security in the context of modern industrial societies. The concept . . . is that individuals contribute to a central fund managed by governments, and this fund is then used to provide income to individuals when they become unable to support themselves through their own labors.”).

11. *Id.* at 4.

12. *Id.* at 7 (noting that “[i]n each of the three major policymaking areas (coverage, benefits, and financing), the program has undergone a slow but dramatic evolution”).

13. *Id.* at 2 (“The need for social insurance became manifest with the coming of the Industrial Revolution.”).

14. *Id.* (noting that in 1880, 72% of the American population lived rurally and 28% lived in cities; in 1930, however, the country was 56% urban and 44% rural so that “the shift . . . undermined traditional strategies for providing economic security and created a need for new forms of social provision”).

15. *Id.*

16. *Id.* at 2 chart 1 (showing that between 1890 and 1930, the percentage of the population in the United States 65 years old or older increased dramatically).

17. *Id.* at 3 (explaining that, although everyone was impacted by the Great Depression, “the elderly were especially hard hit [as] [o]lder workers tended to be the first to lose their jobs and the last to be rehired during economically difficult times”).

18. *Id.* at 4.

19. *Id.* The most well-known and often-cited fund was the Townsend Plan, which promised upwards of \$200 for each retired participant, double what the average monthly income was for a working American. *Id.*

also the economic and social environment for the elderly in the country, President Roosevelt signed the Social Security Act in August of 1935<sup>20</sup> and established both the SSA<sup>21</sup> and the Social Security national old-age pension fund for retired workers.<sup>22</sup>

B. *THE EVOLUTION OF THE SOCIAL SECURITY ACT*

Due to the concerns regarding both the cost of the new Act<sup>23</sup> and also the expected procedural difficulties,<sup>24</sup> the section that focused on Social Security benefits (Title II) was originally very limited in scope. Specifically, Title II did not cover individuals with disabilities and was instead designed for a specific group of people, namely retired individuals, age 65 years or older, who were insured through the program by contributing to the Social Security trust fund each year they worked.<sup>25</sup> However, over the years, both the number of people and the *type* of people who are covered by the Act (and who therefore qualify to receive benefits from the SSA) has steadily increased.<sup>26</sup> Of specific importance to this Note are the amendments and changes made to the Act in 1954 and 1972, both of which expanded Social Security coverage to individuals with disabilities.<sup>27</sup> The final notable evolution includes the current dramatic increase in SSDI and SSI disability claims.

The first major change in the Act regarding disability coverage was the amendment in 1954, which, for the first time, allowed disabled workers to receive Social Security income if they paid into the Social Security trust fund.<sup>28</sup>

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20. *Id.*

21. The SSA was originally called the Social Security Board but was changed to the SSA in 1946. See John R. Kearney, *Social Security and the "D" in OASDI: The History of a Federal Program Insuring Earners Against Disability*, 66 SOC. SECURITY BULL., no. 3, 2006, at 1, 3, 22 n.2.

22. DeWitt, *supra* note 10, at 4 (noting that "the Great Depression is not the *reason* for having a Social Security system . . . The Depression was the *triggering event* that finally persuaded Americans to adopt a social insurance system").

23. *Id.* (noting that although the section of the Act that dealt with Social Security, Title II, was not the most hotly debated topic, one of the main concerns was financing the program).

24. See Kearney, *supra* note 21, at 3-4 (noting the private insurance companies warned the SSA against covering disabled workers because: (1) they had found it very difficult to accurately determine if an individual had a disability; and (2) had struggled to set appropriate financial parameters for coverage and payment for disabled workers).

25. DeWitt, *supra* note 10, at 6.

26. See *id.* at 8 tbl.2 (illustrating both the numerous amendments to the Act between 1935 and 2000 and also the additions to the types of people and situations covered by the Act).

27. *Id.*

28. *Id.* at 12-13. Although 1956 is generally considered to be the year that the SSA began paying SSDI benefits, the framework for the benefits was actually established in the 1954 amendment. *Id.* Congress, fearful that it would be too difficult for the SSA to determine who was disabled, put a "disability freeze" on the amendment whereby an individual who applied for disability insurance would not interrupt the accumulation of his Social Security retirement benefits just because he was unable to work. *Id.*; see also Kearney, *supra* note 21, at 8 (explaining how one of the main reasons for the freeze was so that both proponents and opponents of disability insurance could "declare victory").

These benefits, or Social Security Disability Insurance (“SSDI”), were first delivered nationally in 1956<sup>29</sup> and were once again very limited in scope, illustrating Congress’s worry that covering individuals with disabilities would cost the taxpayer too much.<sup>30</sup> Specifically, SSDI benefits only covered insured, disabled workers who were between the ages of 50 and 64, and did not cover any of the workers’ dependents.<sup>31</sup> However, largely in recognition of the limited financial impact that the SSDI benefits had on the trust fund, the Act was later amended.<sup>32</sup> First, in 1958, SSDI was increased to both cover dependents of disabled workers, and to also allow for up to 12 months of retroactive pay.<sup>33</sup> Secondly, after determining that the age requirement “was arbitrary and had no administrative justification,”<sup>34</sup> the Act was again amended in 1960 to allow any totally disabled worker<sup>35</sup> with Social Security insurance to receive SSDI benefits.<sup>36</sup> Consequently, by 1960, the major foundation for SSDI benefits for insured workers was established. Although both the regulations and processes that claimants are required to follow in order to receive those benefits have evolved over the years,<sup>37</sup> the liberalization

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29. DeWitt, *supra* note 10, at 13.

30. *Id.*; see also Kearney, *supra* note 21, at 11 (explaining that another one of the concerns with expanding coverage to dependents or younger workers was the fear that individuals would quit their jobs in order to receive benefits; due to the low payment of each benefit, however, this concern did not come to fruition).

31. DeWitt, *supra* note 10, at 13.

32. Kearney, *supra* note 21, at 12. The other major concern (that inclusion of individuals with disabilities would encourage establishment of a national health care system) also did not occur. *Id.*

33. DeWitt, *supra* note 10, at 13.

34. Kearney, *supra* note 21, at 22 n.13.

35. In order to receive Social Security benefits (both SSDI and SSI), a claimant must be totally disabled, rather than partially disabled or disabled for only a short time. See SOC. SEC. ADMIN., PUB. NO. 05-10029, DISABILITY BENEFITS 4 (2015), <https://www.ssa.gov/pubs/EN-05-10029.pdf>; see *infra* text accompanying notes 58–59 (explaining the definition of “disability” under the Act).

36. DeWitt, *supra* note 10, at 13.

37. See *infra* Part II.D (explaining how, in recognition of the inconsistent and vague Treating Physician Rule, the SSA changed how medical opinions are weighed by DDSs and ALJs). Interestingly, while the regulations and processes have changed, in some ways dramatically, the definition of “disability” has remained surprisingly constant. Compare *Challenges Facing Social Security Disability Programs in the 21st Century: Hearing Before the Subcomm. on Soc. Sec. of the Comm. on Ways and Means*, 106th Cong. 34 (2000) (statement of Edward D. Berkowitz, Professor and Chair, Department of History, George Washington University) (explaining that planners of the SSA defined disability as “an impairment of mind or body which continuously renders it impossible for the disabled person to follow any substantial gainful occupation [and lasts for] the rest of a person’s life”), with Federal Old-Age Survivors and Disability Insurance, 20 C.F.R. § 404.1505(a) (2016) (defining disability as “the inability to do 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”).

of the Act and SSDI benefits have become a cornerstone of Social Security law for millions of people.<sup>38</sup>

Along with the creation of SSDI, the second major evolution of Social Security income came in 1972, when the Act was again amended to add Title XVI.<sup>39</sup> Under Title XVI, the SSA established monthly SSI benefits for low-income individuals who were blind, disabled, or 65 years old or older.<sup>40</sup> Importantly, while the SSA still manages the program, there was, and still is, no requirement that the recipients contribute to the trust fund or gain insurance through Social Security.<sup>41</sup> Instead, U.S. Treasury funds pay for the program.<sup>42</sup> Consequently, in order to receive SSI benefits for disability, a claimant must show that she is disabled under the definition of the Act and that she makes less, per month, than the statutorily required amount.<sup>43</sup> In addition to the federally funded SSI benefits, many state programs pay supplemental benefits to participants;<sup>44</sup> however, in 2015, only about 16% of SSI recipients also received funding from their state programs.<sup>45</sup> Finally, although the regulations and funds for SSI disability benefits have also changed over time,<sup>46</sup> they too have become a very important aspect of life for millions of Americans.<sup>47</sup>

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38. Specifically, in 2015, 75% of the population between the ages of 20 and 65 (the national retirement age) were insured for disability benefits. SOC. SEC. ADMIN., *supra* note 2, at 11. Additionally, 10,806,000 individuals received SSDI benefits, which comprised approximately 15% of the total number of workers receiving Social Security income. *Id.* at 15. Finally, the average monthly amount for people receiving SSDI for the first time in 2015 was \$1,270. *Id.* at 16.

39. DeWitt, *supra* note 10, at 14.

40. SOC. SEC. ADMIN., PUB. NO. 05-11000, SUPPLEMENTAL SECURITY INCOME (SSI) 1, 4 (2015), <http://www.ssa.gov/pubs/EN-05-11000.pdf>; *see also* Kearney, *supra* note 21, at 23 n.19 (explaining that the SSI benefits “replaced former federal grants to the state . . . with a federal minimum income guarantee”).

41. SOC. SEC. ADMIN., *supra* note 40.

42. *Id.*

43. For a comparison of the medium annual income levels in 1962 and 2014, *see id.* at 5. As of January 2016, an individual claimant whose countable income is more than \$733 is ineligible for SSI benefits. SOC. SEC. ADMIN., PUB. NO. 64-030, 2016 RED BOOK: A SUMMARY GUIDE TO EMPLOYMENT SUPPORTS FOR PERSONS WITH DISABILITIES UNDER THE SOCIAL SECURITY DISABILITY INSURANCE (SSDI) AND SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAMS 2 (2016), <https://www.ssa.gov/redbook/documents/TheRedBook2016.pdf>; *Understanding Supplemental Security Income SSI Income—2016 Edition*, SOC. SECURITY ADMIN., <https://www.ssa.gov/ssi/text-income-ussi.htm> (last visited Dec. 28, 2016).

44. SOC. SEC. ADMIN., PUB. NO. 05-11015, A GUIDE TO SUPPLEMENTAL SECURITY INCOME (SSI) FOR GROUPS AND ORGANIZATIONS 7 (2016), <https://www.ssa.gov/pubs/EN-05-11015.pdf>.

45. SOC. SEC. ADMIN., *supra* note 2, at 26.

46. *See infra* Part II.D (explaining how the SSA changed the ways that medical evidence was weighed by ALJs and DDSs); *see also infra* text accompanying notes 167–68 (explaining how the 2012 SSA amendment gave disability adjudicators at the ALJ and DDS levels more authority over considering conflicting evidence in a claimant’s medical file).

47. In 2015, approximately 8.3 million individuals received SSI benefits. SOC. SEC. ADMIN., *supra* note 2, at 24. Of those recipients, 85%, or approximately 7.1 million, received their benefits



In addition to the important regulatory and doctrinal aspects of SSDI and SSI benefits, the final evolution of the system has been the noticeable increase in the number of individuals applying for SSDI and SSI benefits. In 1965, there were only 529,300 applicants for SSDI benefits;<sup>48</sup> by 2014 that number had increased to over 2.5 million.<sup>49</sup> Similarly, in 1975, there were 1,468,610 SSI applications, while in 2014 there were 2,329,811.<sup>50</sup> There are a few possible reasons for this increase in SSDI benefit applications particularly. The primary cause recently has been the significant downturn in the economy following the 2008 economic crisis. As chief actuary for the SSA, Stephen Gross, explained in 2011, “[w]hen employment is good—when employers are trying to employ lots of people—people with impairments, like everyone else, find it easier to find a job.”<sup>51</sup> However, when the economy is depressed and it is more difficult to find a job, some may find it more reasonable to apply for SSDI while they continue to search for employment.<sup>52</sup> The SSA itself has noted a similar trend among SSI applications as well.<sup>53</sup> A final, connected reason for the increase in applications is the increase in approval rates, particularly among ALJs on appeal.<sup>54</sup> If individuals know that they are much

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because they were disabled. *Id.* at 27.

48. *Disabled Workers Applications for Disability Benefits & Benefit Awards*, SOC. SECURITY ADMIN., <https://www.ssa.gov/oact/STATS/table6c7.html> (last visited Dec. 28, 2016) [hereinafter *Disabled Workers Applications*].

49. *Selected Data from Social Security’s Disability Program*, SOC. SECURITY ADMIN., <https://www.ssa.gov/oact/STATS/dibStat.html> (last visited Dec. 28, 2016). Although the number of applicants has slightly decreased after it peaked in 2010, since 2004, there have never been fewer than 2 million applicants. *Disabled Workers Applications*, *supra* note 48.

50. SOC. SEC. ADMIN., PUB. NO. 13-11827, SSI ANNUAL STATISTICAL REPORT, 2014, at 119 tbl. 57 (2015), [https://www.ssa.gov/policy/docs/statcomps/ssi\\_asr/2014/ssi\\_asr14.pdf](https://www.ssa.gov/policy/docs/statcomps/ssi_asr/2014/ssi_asr14.pdf).

51. Damian Paletta & Dionne Searcey, *Jobless Tap Disability Fund*, WALL STREET J. (Dec. 28, 2011), <http://www.wsj.com/articles/SB10001424052970204296804577121392750460030>. Interestingly, unlike perhaps the regular retirement benefits, aging does not appear to directly impact the number of SSDI applications. John Merline, *The Sharp Rise in Disability Claims*, REGION FOCUS, Second/Third Quarter, 2012, at 24 (noting that the average age of people applying for SSDI benefits has actually slightly decreased since the 1980s).

52. Merline, *supra* note 51, at 24–25 (citing Mark Duggan, a professor at the University of Pennsylvania, to suggest that in 2011, the higher unemployment rates accounted for 3,000 additional people applying for benefits *each week*); Paletta & Searcey, *supra* note 51 (“[M]any desperate Americans seek[] refuge in the program as a last resort after their unemployment insurance and savings run out.”). This issue is often compounded by the fact that once a person begins to receive SSDI benefits, they are unlikely to ever return to the workforce. Merline, *supra* note 51, at 24; *see also* PERMANENT SUBCOMM. ON INVESTIGATIONS, *supra* note 4, at 7.

53. SOC. SEC. ADMIN., ANNUAL REPORT OF THE SUPPLEMENTAL SECURITY INCOME PROGRAM 30–32 (2011) (“We presume that the current downturn caused the recent large increase in applications. During the continued economic slowdown, we project higher levels of unemployment, resulting in substantially more applications than the general trend suggests.”).

54. *See* PERMANENT SUBCOMM. ON INVESTIGATIONS, *supra* note 4, at 72–73 (describing how one ALJ had an approval rate of between 90% and 100%); Thomas Katsiotas, Comment, *The Last Days of Social Security Disability: How the Social Security Administration’s Policies on the Submission of Adverse Evidence and Non-Attorney Representation Have Contributed to Its Institutional Failure*, 63 BUFF. L. REV. 685, 693–94 (2015) (explaining that in response to the backlog, the SSA instituted a

more likely to receive benefits if they appeal their initial denial, more people may decide to apply in the first place, particularly given the economic climate.<sup>55</sup> Unfortunately, although the economy may be rebounding, the SSA has noted that the number of backlogged pending claims will likely not decrease to the pre-Recession levels.<sup>56</sup> As this Note discusses in Part IV, one solution for moving through the increasing number of applications both quickly and accurately is to provide medical specialist MCs at the DDS level investigation.<sup>57</sup>

### C. THE PROCESS FOR RECEIVING SSI AND SSDI BENEFITS

Although the SSDI and SSI programs have different economic eligibility requirements and receive funding from different sources, they both share at least one vital characteristic: the same definition of “disability.”<sup>58</sup> The SSA defines disability for both programs “as the inability to do 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.”<sup>59</sup> Substantial gainful activity is “work that [] (a) [i]nvolves doing significant and productive physical or mental duties; and (b) [i]s done . . . for pay or profit.”<sup>60</sup> A medical “impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques.”<sup>61</sup>

Another commonality between the SSDI and SSI programs is how an individual’s claim is adjudicated. When a claimant files a claim with the SSA regional office, the claim is sent to the DDS office in the claimant’s state.<sup>62</sup> A disability examiner (“DE”) will primarily be responsible for gathering the necessary information to make a disability determination,<sup>63</sup> and may require

“‘paying-down-the-backlog’ policy” and encouraged ALJs to approve as many claims as possible); Pierce, Jr., *supra* note 4, at 34 (noting that between 2007 and 2010, the number of ALJ decisions granting benefits increased 28%).

55. See Merline, *supra* note 51, at 25.

56. OFFICE OF THE INSPECTOR GEN., SOC. SEC. ADMIN., THE SOCIAL SECURITY ADMINISTRATION’S PROGRESS IN REDUCING THE INITIAL DISABILITY CLAIMS BACKLOG 5 (2014), [https://oig.ssa.gov/sites/default/files/audit/full/pdf/A-07-13-13073\\_0.pdf](https://oig.ssa.gov/sites/default/files/audit/full/pdf/A-07-13-13073_0.pdf).

57. See *infra* Part IV.A.

58. *Disability Evaluation Under Social Security: Part I—General Information*, SOC. SECURITY ADMIN., <http://www.ssa.gov/disability/professionals/bluebook/general-info.htm> (last visited Dec. 28, 2016). Importantly, the definition only applies to those individuals covered under Title II and *adults* receiving disability SSI benefits under Title XVI. *Id.*

59. 20 C.F.R. § 404.1505(a) (2016).

60. *Id.* § 404.1510(a)–(b). The substantial gainful activity amount as of January 2016 is \$1,130 per month. SOC. SEC. ADMIN., *supra* note 43, at 2.

61. 20 C.F.R. § 404.1508.

62. SOC. SEC. ADMIN., *supra* note 35, at 8. Importantly, when a DDS official investigates a claim of disability, she must follow the same rules articulated by the SSA. 20 C.F.R. § 404.1615(a).

63. 20 C.F.R. § 404.1512(d) (noting that the SSA has the responsibility to fully develop the

the claimant to attend an additional consultative examination for more specific evidence if the information the claimant submitted is insufficient.<sup>64</sup> Under section 404.1615(c), there are four types of officials, or groups of officials, who are authorized to make an initial determination of disability at the DDS level. However, for the purposes of this discussion, this Note will only focus on the first two, as they are the most likely to occur: (1) DEs, together with state agency medical or psychological consultants; and (2) DEs by themselves, but only “when there is no medical evidence to be evaluated” (i.e., “despite making every reasonable effort,” the DE has been unable to retrieve the necessary information from the claimant) and “the individual [applying for benefits] fails or refuses, without a good reason, to attend a consultative examination.”<sup>65</sup>

After considering all of the medical and non-medical evidence (such as the claimant’s work history or current unearned or earned income)<sup>66</sup> and the facts of the case, a DE (or a DE together with a state agency medical or psychological consultant) will decide whether the claimant is disabled under the regulations.<sup>67</sup> If he is, then the claimant will begin to receive SSDI or SSI benefits (or both).<sup>68</sup> However, if the claimant’s application is denied, the

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record and get appropriate medical evidence before making a determination).

64. *Id.* § 404.1520b(c)(3).

65. *Id.* § 404.1615(c)(1)–(c)(2). The other two individuals authorized to make disability determinations are: (1) DEs, by themselves, when the claim is adjudicated under two specific programs and the *entire* result is favorable to the claimant; and (2) state agency disability hearing officers. *See id.* § 404.1615(c)(3)–(c)(4). The two programs under section (c)(3) are the “quick disability determination program” and the “compassionate allowance process.” *Id.* § 404.1615(c)(3). While the former still encourages DEs to consult with MCs, it does allow DEs to make determinations without consulting with them only if the determination is “fully favorable” and in situations where there is “a high degree of probability” that the person’s claim will lead to a disability determination. *Id.* § 404.1619. Importantly, section (c)(3) may be eliminated on December 28, 2018 unless the SSA eliminates it sooner or decides to extend the program. *Id.* § 404.1615(c)(3). Even if the SSA decides to extend the program, however, doing so would exacerbate some of the issues described in Part III.B of this Note. Specifically, it would further allow DEs to make determinations without getting the opinion of a trained medical specialist (or even any licensed medical individual). It will also likely incentivize DEs to make quicker decisions to *approve* claims in order to apply this program and get through the backlog more quickly, thereby adding to the number of individuals who receive SSDI and SSI benefits (correctly or incorrectly) and further increasing the strain on the SSA system. Finally, such a policy largely contradicts the SSA’s stated policy of “ensur[ing] that the right set of medical eyes reviews medical records and answers questions about the wide variety of impairments seen in disability claims.” Administrative Review Process for Adjudicating Initial Disability Claims, 70 Fed. Reg. 43,590 (July 27, 2005) (to be codified at 20 C.F.R. pts. 404, 405, 416, and 422).

66. For SSI benefits, the DDS official must ensure that the claimant falls under the required monthly income, which is composed of the claimant’s earned and unearned income. SOC. SEC. ADMIN., *supra* note 44, at 11.

67. 20 C.F.R. § 404.1615(c) (2016).

68. *Disability Determination Process*, SOC. SECURITY ADMIN., <https://www.ssa.gov/disability/determination.htm> (last visited Dec. 28, 2016) (explaining that, after the DDS makes a positive decision on a disability claim, the DDS returns the case to the SSA federal field office, which computes the benefit amount and begins paying the claimant benefits).

claimant may appeal the decision for reconsideration, whereby a new DE (again, likely coupled with a consultant) will consider the facts *de novo* and make her own decision.<sup>69</sup> Following this, the claimant may appeal the decision to an ALJ,<sup>70</sup> an Appeals Council review,<sup>71</sup> and finally a federal court review.<sup>72</sup> Importantly, after the claimant has appealed his case up to and including the Appeals Council review, whatever decision is made at that level is the final decision of the SSA on the matter.<sup>73</sup>

In making these determinations, each SSA or DDS official must follow a five-step analysis.<sup>74</sup> If, after each step, the SSA cannot determine whether the person is disabled, the adjudicator will move on to the next step.<sup>75</sup> From step two forward, the SSA official considers medical opinion evidence as it relates to the claimant's claim.<sup>76</sup> Under the first step, the SSA official considers whether the claimant is engaged in substantial gainful activities; if the claimant is, the SSA will find that the individual is not disabled; however, if the claimant is not engaged in a substantial gainful activity, the SSA will move on to the second step.<sup>77</sup> At the second step, the SSA will consider the medical severity of the claimant's impairments to determine whether, taken together, the claimant's impairments are sufficiently severe under the regulations; if they are not sufficiently severe, then the claimant is not disabled; however, if they are, the SSA moves on to the third step.<sup>78</sup> Under the third step, the SSA will again consider the severity of the claimant's impairments; however, at this stage, the SSA will specifically determine whether the impairments "meet[] or

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69. 20 C.F.R. § 404.900(a)(2). The claimant may also appear before a disability hearing officer. SOC. SEC. ADMIN., PUB. NO. 05-10068, REVIEWING YOUR DISABILITY 2 (2015), <http://www.ssa.gov/pubs/EN-05-10068.pdf>.

70. 20 C.F.R. § 404.900(a)(3). Importantly, while an ALJ is not bound by the decision of medical consultants, because the consultants are knowledgeable of the regulations and reviewed the entire record, the ALJ must consider their determinations of fact as expert medical opinions. SSR 96-6P, 1996 WL 374180 (July 2, 1996).

71. 20 C.F.R. § 404.900(a)(4).

72. *Id.* § 404.900(a)(5).

73. *Id.* Therefore, if the Appeals Council affirms the ALJ's decision or, alternatively, refuses to hear the appeal, then the decision of the ALJ is the final decision of the SSA. Only then can the claimant file an appeal in federal court. *Id.* § 404.981.

74. *Id.* § 404.1520(a)(4); *see also id.* § 404.1615(a) (explaining that when a DDS official determines whether a person is disabled, she must follow the same process as ALJs or federal government officials). For purposes of simplicity, during this section I will use the term "SSA" to refer to all SSA officials authorized to make a determination of disability, including DDS officials and ALJs.

75. *Id.* § 404.1520(a)(4).

76. *See infra* Part II.D for an explanation of how the SSA official must consider and weigh medical opinion evidence during these steps.

77. 20 C.F.R. § 404.1520(a)(4)(i) (2016). Again, "[s]ubstantial gainful activity means work that—(a) [i]nvolves doing significant and productive physical or mental duties; and (b) [i]s done . . . for pay or profit." *Id.* § 404.1510.

78. *Id.* § 404.1520(a)(4)(ii). The impairments must be so severe that the claimant is unable to engage in substantial gainful activities for at least 12 months. *Id.*; *see also id.* § 404.1509.

equal[] one of [the] listings in appendix 1 of” subpart P, commonly referred to as the Listing of Impairments.<sup>79</sup> If the SSA establishes that the “impairment(s) does not meet or equal” an impairment on the list, the SSA will then determine the claimant’s Residual Functional Capacity (“RFC”),<sup>80</sup> which “is the most [a claimant] can still do despite [her] limitations” based on the relevant medical evidence in the record.<sup>81</sup>

At the fourth step, the SSA will use the RFC it has just calculated and determine whether, based on that RFC, the claimant can continue to do her past work.<sup>82</sup> If the individual can return to her original work, then the claimant is not disabled; however, if the claimant cannot return, the SSA will move on to the fifth and final level.<sup>83</sup> At this step, the SSA will consider whether, based on the claimant’s RFC and other vocational considerations (the claimant’s “age, education, and work experience”), the claimant will be able to make an adjustment and find work elsewhere.<sup>84</sup> Importantly, while the claimant generally has the burden of proof to show that she is disabled,<sup>85</sup> at this final stage, the SSA itself must come forward with evidence that, given the claimant’s RFC and vocational factors, there are a sufficient number of jobs available for the claimant “in the national economy.”<sup>86</sup> If there is evidence that the claimant can return to another job in the national economy given her RFC, then the SSA will determine that she is not disabled; otherwise, the claimant is disabled under SSA regulations.<sup>87</sup>

#### D. WEIGHING MEDICAL OPINIONS

A final aspect of the SSA disability determination process that is necessary to discuss is how DDSs and ALJs must weigh the medical opinions in the claimant’s record. Pursuant to section 404.1527, DDSs and ALJs are required, “regardless of [the] source” of the medical opinion, to analyze and “evaluate every medical opinion [they] receive.”<sup>88</sup> This regulation was established in 1991, largely in response to the confusion that its legal predecessor, the

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79. *Id.* § 404.1520(a)(4)(iii); see also *Disability Evaluation Under Social Security: Listing of Impairments—Adult Listings (Part A)*, SOC. SECURITY ADMIN., <https://www.ssa.gov/disability/professionals/bluebook/AdultListings.htm> (last visited on Dec. 28, 2016). This Listing is a list that “describes medical conditions that [the SSA] consider[s] severe enough to prevent a person from completing substantial gainful activity, regardless of age, education, or work experience.” SOC. SEC. ADMIN., *supra* note 35, at 10. If the claimant’s injury “meets or equals the severity of” an impairment on that list, the claimant is automatically disabled. *Id.*

80. 20 C.F.R. § 404.1520(e).

81. *Id.* § 404.1545(a)(1).

82. *Id.* § 404.1520(a)(4)(iv).

83. *Id.*

84. *Id.* § 404.1520(a)(4)(v).

85. *Id.* § 404.1512(a).

86. *Id.* § 404.1560(c)(1)–(c)(2).

87. *Id.* § 404.1520(a)(4)(v).

88. *Id.* § 404.1527(c).

“Treating Physician Rule,” was causing in federal courts.<sup>89</sup> Under the SSA’s regulation, “[m]edical opinions are statements from physicians and psychologists . . . that reflect judgments about the nature and severity of [the claimant’s] impairment(s).”<sup>90</sup> Importantly, under section 404.1527(c)(2), if the SSA finds that the claimant’s treating source’s medical opinion is: (1) “well-supported by medically acceptable clinical and laboratory diagnostic techniques”; and (2) “not inconsistent with the other substantial evidence in [the] record,” the SSA will give the treating physician’s opinion “controlling weight.”<sup>91</sup> However, when the SSA official is making a determination on an issue that is reserved for the Commissioner (such as whether the person is disabled, whether the claimant’s disability is severe under the Listing of Impairments, or what the claimant’s RFC is), the SSA “will not give any special significance to the source of an opinion.”<sup>92</sup>

Consequently, if, at any review level, the SSA official decides not to give controlling weight to the treating physician’s opinion, the official must then consider multiple factors when determining how much weight to give the medical opinion.<sup>93</sup> Specifically, if the official is examining a treating physician’s opinion, then she must consider (1) the length of the treatment relationship and (2) the nature and extent of the treatment relationship.<sup>94</sup> In addition to this, and regardless of the source of the opinion, the official must consider five additional factors: the examining relationship (whether the doctor giving the opinion examined the claimant), the supportability of the opinion in the medical evidence, the consistency of the opinion with the medical evidence, the specialization of the source, and any other factors the claimant raises.<sup>95</sup> Finally, if an ALJ is reviewing the file, the determination by the MC at the DDS level is considered “opinion evidence” and therefore must

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89. James A. Maccaro, *The Treating Physician Rule and the Adjudication of Claims for Social Security Disability Benefits*, N.Y. ST. B.J., Nov. 1992, at 29 (describing: (1) the Rule, which is “based on the rationale that . . . treating physician[s] [are the] best suited to render a medical appraisal” because they are the most familiar with the claimant’s individual condition and symptoms; and (2) the inconsistencies between circuits that hold the treating physician’s view *must* be followed and circuits that hold that the opinion should just be a factor for the court); *see also* Cathryn Miller-Wilson, *Medical-Legal Partnerships: Origins and Ethical Lessons*, 93 NEB. L. REV. 636, 663 (2015) (explaining that the confusion between the courts about how to weigh medical opinion evidence, along with the SSA’s desire to be more efficient and accurate, encouraged the SSA to create its own rule regarding the issue in 1991).

90. 20 C.F.R. § 404.1527(a)(2) (2016).

91. *Id.* § 404.1527(c)(2).

92. *Id.* § 404.1527(d)(1)–(d)(3). Specifically, the SSA has explained that to give controlling weight to the treating sources in those instances would effectively “confer upon the treating source the authority to make the [disability] determination.” SSR 96-5p, 1996 WL 374183, at \*2 (July 2, 1996).

93. 20 C.F.R. § 404.1527(c).

94. *Id.* § 404.1527(c)(2)(i)–(ii).

95. *Id.* §§ 404.1527(c)(1), 404.1527(c)(3)–(c)(6).

be considered and weighed using the same factors listed above.<sup>96</sup> At all levels of review, the SSA official must give “good reasons” for her decision regarding the weight assigned to each medical opinion.<sup>97</sup> Therefore, an ALJ may often be comparing an MC medical opinion on the same level as a treating physician’s opinion, even though the MC has likely never met with the claimant and is likely not a specialist in the medical area of the claimant’s disability.<sup>98</sup> As explained in Part IV of this Note, some of the concerns this Note raises regarding the use of medical experts at the DDS and ALJ review levels may be mitigated by establishing more precise and detailed requirements under this section of the SSA regulations.<sup>99</sup>

### III. ISSUES RELATED TO NON-SPECIALIST MEDICAL CONSULTANTS

This Part first discusses the importance of MCs at the initial disability determination level of DDS review, and will also briefly explain the requirements of becoming a SSA MC. It then examines some of the inherent issues that arise when the MCs reviewing DDS disability claims are not experts in the claimant’s reported disability, including inconsistencies between the decisions made by different DDSs and the mistrust this creates for the American public. Finally, this Part examines how certain current SSA policies have aggravated the concerns surrounding non-specialized MCs. These policies include the push to diminish the backlog of DDS initial disability decisions and an SSA amendment passed in 2012, which has increased the decision-making authority afforded to DDSs and ALJs.

#### A. THE IMPORTANCE AND QUALIFICATIONS OF MEDICAL CONSULTANTS

As explained above, when someone files a complaint for SSDI or SSI disability benefits, the claim will be forwarded to state DDSs, which will review the claim and make an initial decision about whether the person is disabled under SSA regulations.<sup>100</sup> Although a DE is allowed to make a decision on her own if the decision requires no medical evidence or is adjudicated under two programs that may be eliminated in 2018,<sup>101</sup> because of the high number of

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96. *Id.* § 404.1527(e)(2)(i).

97. *Id.* §§ 404.1527(c)(2), 404.1527(e)(2)(ii).

98. *See* SOC. SECURITY ADMIN., *Medical/Professional Relations*, <https://ssa.gov/disability/professionals/answers-pubo42.htm> (last visited Dec. 28, 2016) (explaining that MCs rarely meet with a claimant and instead primarily rely on the documents in the claimant’s file); *infra* notes 126–28 and accompanying text (detailing the importance of having medical specialists examine a patient); *infra* Part III.B (detailing the issues that non-specialist MCs cause for the disability determination process). If ALJs are comparing the MC’s medical opinion on the same level as a treating physician’s opinion, the public’s mistrust of the accuracy of the disability decisions will become even more acute. *See infra* Part III.B.1.

99. *See infra* Part IV.B.

100. SOC. SEC. ADMIN., *supra* note 35, at 8–10.

101. 20 C.F.R. § 404.1615(c)(2)–(c)(3) (2016) (explaining that a DE can make a decision independently if there is no medical evidence, if the person does not submit to a consultative

cases that must be decided based on medical evidence, the opinions and decisions of MCs are a very important component in the initial disability determination process.<sup>102</sup> Specifically, based on data generated by the SSA, in 2013 there were approximately 1,770,826 medical decisions made at the initial SSDI adjudication level and 1,933,420 medical decisions made at the initial SSI adjudication level.<sup>103</sup> Furthermore, at all levels of adjudicative review, approximately 59% of SSDI determinations and 77% of SSI determinations were medically based,<sup>104</sup> thereby illustrating how often medical and psychological consultants will likely work with DEs in order to review a disability claim.

Based on the persistent need for medically-based determinations, and consequently the need for MCs, it is necessary to next detail both the specific duties of MCs and also their qualifications under SSA regulations. As explained above, “MCs . . . play an important role in assembling and interpreting the medical record that is the basis for a disability determination decision.”<sup>105</sup> Specifically, when an MC makes a decision with a DE, the MC is responsible for determining the claimant’s RFC, the severity of the claimant’s impairment, and whether the impairment meets or equals a medically listed impairment on the List of Impairments; these decisions are findings of fact.<sup>106</sup> If the MC is merely consulted by the DE on certain medical aspects of the claim, however, the MC’s decision becomes opinion evidence that must be weighed using the same five factors detailed in Part II.D.<sup>107</sup> Along with being

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examination (CE), or the claim is being adjudicated under two programs that may be eliminated in November 2016); *see also supra* notes 63–73 (explaining the pitfalls and concerns of the two DE-centered programs).

102. *See* INST. OF MED. OF THE NAT’L ACADS., IMPROVING THE SOCIAL SECURITY DISABILITY DECISION PROCESS app. C at 176 (2007) (noting that “[i]n most DDSs, the MC works with a trained layperson, called a disability examiner (DE), on a two-person team to make the disability decision jointly”). As will be explained below, this Note focuses on MCs, not psychological consultants. This is primarily done because, unlike the majority of MCs, psychological consultants are required to be experts in the “field” of the claimant’s impairment (i.e. psychology or psychiatry); consequently, the concerns that arise from using non-specialist MCs are not as prevalent for psychological consultants.

103. SOC. SEC. ADMIN., *supra* note 5, at 150 tbl.61; SOC. SEC. ADMIN., *supra* note 50, at 143 tbl.70. Additionally, there were 567,774 medical decisions made at the SSDI reconsideration level and 32,508 at the SSDI hearing level or above. SOC. SEC. ADMIN., *supra* note 5, at 152 tbl.61, 154 tbl.63. There were 563,006 medical decisions made at the SSI reconsideration level and 34,325 at the SSI hearing level or above. SOC. SEC. ADMIN., *supra* note 50, at 145 tbl.71, 147 tbl.72.

104. *See* SOC. SEC. ADMIN., *supra* note 5, at 148 tbl.60 (illustrating that in 2013, excluding the number of pending decisions, 1,307,587 (or about 59%) of the 2,220,372 SSDI decisions made at all adjudication levels were medically based); SOC. SEC. ADMIN., *supra* note 50, at 141 tbl.69 (illustrating that in 2013, excluding the number of pending decisions, 1,501,877 (or about 77%) of the 1,938,413 SSI decisions made at all adjudication levels were medically based).

105. INST. OF MED. OF THE NAT’L ACADS., *supra* note 102, at 176; *see also* 20 C.F.R. § 404.1616(a) (defining a “medical consultant” as “a person who is a member of a team that makes disability determinations in a State agency . . .”).

106. 20 C.F.R. § 404.1527(e)(1)(i) (2016).

107. *Id.* § 404.1527(e)(1)(ii).



responsible for helping to establish the claimant's medical record and assisting with making the necessary findings of fact, MCs who work in either the DDSs or federal, regional SSA offices "assist in quality assurance review of claim adjudications."<sup>108</sup> Therefore, not only do MCs play a vital role in determining whether someone is disabled under the regulations, but they also assist the SSA in ensuring that the SSA's policies are consistently and adequately applied.

Although MCs are key contributors to the disability determination process, unlike psychological consultants, the qualifications for being an SSA MC are decidedly broad in relation to the important role they play. Specifically, under section 404.1616(f), psychological consultants are permitted to only evaluate mental impairments, in recognition of the fact that psychologists have specialized knowledge in psychologically-based medicine and are only qualified to provide medical opinions in that field.<sup>109</sup> However, in order to be an MC, the "consultant must be an acceptable medical source . . . that is, a licensed physician (medical or osteopathic), a licensed optometrist, a licensed podiatrist, or a qualified speech-language pathologist. The medical consultant must meet any appropriate qualifications for his or her specialty . . .".<sup>110</sup> Therefore, unless someone is claiming disability based on blindness, an impairment of the foot, or a speech-language-based impairment, the only requirement under the SSA regulations for an MC to provide a medical disability determination is for the doctor to be a licensed physician with the appropriate qualifications for his specialty.<sup>111</sup> Thus, as long as the MC is a licensed physician, a cardiologist MC can review the file of a claimant asserting an orthopedic injury and make medical determinations about the severity of the impairment or the claimant's RFC.<sup>112</sup>

Along with requiring only broad qualifications for MCs, it is important to note that while the SSA has acknowledged some of the limitations in allowing

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108. INST. OF MED. OF THE NAT'L ACADS., *supra* note 102, at 177.

109. 20 C.F.R. § 404.1616(f) (explaining that psychological consultants can make determinations for the DDS "only when a mental impairment is the only impairment in the claim or when there is a combination of a mental impairment with another impairment but the mental impairment alone would justify a finding of disability").

110. 20 C.F.R. § 404.1616(b).

111. *Id.* § 404.1616(c) (noting that "[m]edical consultants who are not physicians are limited to evaluating the impairments for which they are qualified"). As an example, the SSA explains that a speech-language MC can only get involved in a case if: (1) the speech-language impairment is the only issue; or (2) there is a combination of impairments but the speech-language impairment is sufficient on its own to render the person disabled. *Id.*

112. *See, e.g.,* Rodriguez Pagan v. Sec'y of Health & Human Servs., 819 F.2d 1, 3 (1st Cir. 1987) (holding that it was not dispositive that the consultant was a cardiologist and the man was complaining of an orthopedic injury); Parker v. Colvin, No. 2:13-cv-286-DBH, 2014 WL 3533323, at \*3 (D. Me. July 15, 2014) (stating that despite the fact that the claimant's impairment was Parkinson's disease, it did not matter that the treating physician was a neurologist and the consulting physician was an internist).

non-specialist MCs to evaluate disability claims,<sup>113</sup> the primary focus by the SSA has consistently been on the MCs' "three domains of knowledge": first, "[m]edical consultants must be experts in their medical field (e.g., cardiology and orthopedics)"; second, "they need to understand how to evaluate [the] disability"; and third, "they must be knowledgeable about SSA's policies and procedures."<sup>114</sup> Not only do none of these factors relate directly to how the MC's specialty relates to the claims she is evaluating, but the SSA has focused primarily on the last two areas of knowledge over the first,<sup>115</sup> thereby emphasizing knowledge of policy and regulations over having a firm base of medical knowledge in the area of the claimant's impairment.

Finally, although a consultant's specialty is an enumerated factor that DDS officials and ALJs must consider when the MC's evaluation is considered opinion evidence rather than a finding of fact,<sup>116</sup> the adjudicator does not have to specifically explain in her decision how she weighed the specialty of the doctor providing medical evidence. This regulation adds to the demphasis of the MC's medical specialty in the determination process and makes it much more difficult for future ALJs to determine how best to consider and weigh an MC's specialty. Consequently, and as explained below, by refusing to adequately respond to the need to have specialist MCs in the DDSs, the SSA's disability determination process has deteriorated and will likely continue to do so unless the SSA takes necessary steps in this preliminary area. And while there are inherently some supply-and-demand issues related to hiring and maintaining large numbers of specialist MCs,<sup>117</sup> the Note's first suggestion responds directly to this concern.

#### B. INHERENT ISSUES FOR NON-SPECIALIST MCs

This Subpart identifies two specific issues that arise partly due to using non-specialist MCs to review a wide variety of medical impairments: (1) the reduction in the public's trust in the SSA process; and (2) the difference in DDS allowance rates nationally. This Subpart will further analyze these problems, and the SSA's awareness of them, by examining the ultimately

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113. See *infra* Part III.B.

114. Administrative Review Process for Adjudicating Initial Disability Claims, 71 Fed. Reg. 16,424, 16,432 (Mar. 31, 2006) (to be codified at 20 C.F.R. pts. 404, 405, 416, and 422).

115. *Id.* at 16,432 (explaining that in an attempt to standardize the quality of the medical experts available to the DDSs and ALJs, the SSA "will concentrate on the second and third domains"); see also INST. OF MED. OF THE NAT'L ACADS., *supra* note 102, at 187 (explaining that DDS provides training to MCs, but only focuses that training on educating the MCs "on disability evaluation and Social Security program definitions and requirements"). Although the SSA and DDSs certainly provide MCs with necessary medical training, the emphasis on training is to follow the SSA regulations as they apply to determining whether a claimant has a disability.

116. 20 C.F.R. § 404.1527(c)(5) (2016).

117. See *infra* notes 136–40 and accompanying text (explaining the limited number of specialist MCs available nationwide).

unsuccessful 2006 policy that the SSA passed in an attempt to improve the specialty of the MCs available during the disability determination process.

### 1. Reduction in the Public's Trust

One of the primary concerns created by allowing non-specialist MCs to participate in determinations involving all types of medical claims is that such decisions often create the appearance of unfairness and arbitrariness. Take, for example, the case of Mr. William Bunn,<sup>118</sup> who was diagnosed with small-fiber neuropathy in 2009 and was subsequently forced to quit his job as a truck driver due to pain and numbness in his legs.<sup>119</sup> Although his SSA application included notices from two private doctors regarding the severity of his impairment, his application was rejected after two reviews by the Illinois DDS, one of which was performed by a pediatrician who had neither met nor examined Mr. Bunn.<sup>120</sup> Although an ALJ eventually reversed the decision based on Mr. Bunn's objection to the pediatrician's review, this was a "rare move" by the ALJ<sup>121</sup> and Mr. Bunn had to wait approximately 430 days between the date of his initial denial and the date his benefits were eventually awarded.<sup>122</sup>

This type of decision negatively impacts the public's ability to trust the SSA's process for two reasons. First, allowing a non-examining pediatrician's opinion to win out over the opinion of a treating physician, especially when the majority of the pediatrician's career has focused on child-related ailments, understandably smacks of inherent unfairness to the claimant. The claimant, who has suffered a very particularized injury, should be able to expect that his

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118. Although Mr. Bunn's story may not contribute to or demonstrate any quantifiable systematic cost to the SSA process, it does illustrate the personal impact that this concern may have. Such consideration is necessary to fully understand the impact of the non-specialist MC issue.

119. Damian Paletta, *Doctor Revolt Shakes Disability Program*, WALL STREET J. (Nov. 21, 2011), <http://www.wsj.com/articles/SB10001424052970204621904577016221945984492>.

120. *Id.*

121. *Id.* (noting that "[t]he judge, in a rare move, awarded benefits on the spot"). *The Wall Street Journal's* surprise regarding the ALJ's decision was not unwarranted, given some courts' rejection of the importance of a consultant's specialty. See *Rodriguez Pagan v. Sec'y of Health & Human Servs.*, 819 F.2d 1, 3 (1st Cir. 1987) (holding that it was not dispositive that the consultant was a cardiologist and the man was complaining of an orthopedic injury); *Parker v. Colvin*, No. 2:13-cv-286-DBH, 2014 WL 3533323, at \*3 (D. Me. July 15, 2014) (stating that it did not matter that the treating physician was a neurologist (the medical area of the claimant's impairment) and that the consulting physician was an internist).

122. *Hearing Office Average Processing Time Ranking Report*, SOC. SECURITY ADMIN. (Sept. 24, 2010), [https://www.ssa.gov/appeals/DataSets/archive/05\\_FY2010/05\\_September\\_Average\\_Processing\\_Time\\_Ranking\\_FYTD2010.html](https://www.ssa.gov/appeals/DataSets/archive/05_FY2010/05_September_Average_Processing_Time_Ranking_FYTD2010.html) (showing that between September 26, 2009 and September 24, 2010, the average processing time at the hearing office level was 430 days for Evanston, Illinois). Today, that same trip would take Mr. Bunn 496 days. *Hearing Office Average Processing Time Ranking Report*, SOC. SECURITY ADMIN. (Sept. 26, 2015), [https://www.ssa.gov/appeals/DataSets/archive/05\\_FY2015/05\\_September\\_Average\\_Processing\\_Time\\_Report.html](https://www.ssa.gov/appeals/DataSets/archive/05_FY2015/05_September_Average_Processing_Time_Report.html) (showing that between September 27, 2014 and September 25, 2015, the average processing time at the hearing office level was 496 days for Evanston, Illinois).

claim will be reviewed by someone who is familiar not just with the SSA regulations, but also with the ways in which his particularized injury may impact his ability to work.<sup>123</sup> Putting aside some of the logistical concerns of such an expectation (which this Note will consider in Part IV), by allowing a non-specialist MC to review the claim, the SSA creates the appearance of unfairness and arbitrariness among claimants, as most claimants are generally very aware that medical specialists often possess limited knowledge outside their specialty.<sup>124</sup> These claimants are consequently more likely to appeal any denial if they believe that their claim was not adequately reviewed by someone in the appropriate medical field.<sup>125</sup>

Second, this problematic illustration of Mr. Bunn's case suggests that the SSA often ignores the important input that specialists can have on the determination process,<sup>126</sup> thereby damaging the public's trust that the claimants who *are* approved for disability benefits are actually adequately disabled under the SSA regulations. Specifically, although MCs are all trained physicians, they are also specialized doctors, many of whom "haven't practiced outside their specialty in decades, if at all."<sup>127</sup> Therefore, while a cardiologist may be able to read medical data relating to a claimant's orthopedic injury,

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123. INST. OF MED. OF THE NAT'L ACADS., *supra* note 102, at 173 (noting that, along with economic reasons, specialist MCs are "also justified on the grounds that every applicant for disability benefits should have the benefit of the expertise needed to evaluate their case").

124. See Sarah Pressman Lovinger, *David Meltzer, Physician and Economist, Discusses the New Hospitalist Movement*, 289 J. AM. MED. ASS'N 411, 412 (2003) (quoting Dr. David Metzler as he explains that patients understand the importance of medical specializations as opposed to primary care when it comes to specialized ailments, such as neurological procedures).

125. While a decision by a DE alone may also create a sense of unfairness and lead to additional appeals, a DE is not medically licensed and will also likely only make a disability decision by herself when a denial is more understandable and fact-based for the claimant (such as when a claimant is collaterally estopped from continuing with her claim) or when the decision is completely approved under the two accelerated programs, making an appeal moot. 20 C.F.R. § 404.1619(b) (2016). Conversely, because the public understands the often-singular abilities of specialists to only practice medicine within that specialty, see generally Lovinger, *supra* note 124, a medically based denial by a non-specialist MC will lead to greater feelings of unfairness and therefore more appeals than in other situations. See also INST. OF MED. OF THE NAT'L ACADS., *supra* note 102, at 173 ("If cases could be better evaluated and the medical record more fully developed at the beginning of the process, there might be fewer appeals and fewer allowances on appeal."). This is especially true because MCs generally do not personally examine the claimant before making decisions or recommendations. *Medical/Professional Relations*, SOC. SECURITY ADMIN. (Sept. 1998), <https://ssa.gov/disability/professionals/answers-pubo42.htm> (answering question number nine by explaining that the DDS team (including MCs) relies "entirely on the evidence in the claims folder").

126. Paletta, *supra* note 119 (according to an ex-MC, such inconsistencies clearly suggest that the SSA "think[s] that a doctor is a doctor is a doctor" and that "they [don't] have an understanding or an appreciation of what a specialist's input can add"). This unfairness was well illustrated and confirmed by a Minority Staff Report prepared by the Senate in 2012, in which the authors explained that a DDS review was inadequate or insufficient when, *inter alia*, "doctors from the wrong medical field provided the key diagnosis." PERMANENT SUBCOMM. ON INVESTIGATIONS, *supra* note 4, at 112.

127. Paletta, *supra* note 119.

the cardiologist will have a much harder time relating that data to the severity of the orthopedic injury or determining the person's RFC. Additionally, the cardiologist has not been consistently exposed to the complexities of orthopedic injuries since the beginning of his career the way that an orthopedic specialist has; therefore, many of the subtleties of orthopedic injuries that may make a specific injury disabling will frequently be lost on the cardiologist.<sup>128</sup> Consequently, although the SSA regulations do not require that MCs be experts in the field of the claimant's impairment, failing to do so ignores the complexities of medical injuries, forms the basis of lengthy and expensive reviews for claimants like Mr. Bunn,<sup>129</sup> and severely limits the trust the public and Congress has in the SSA's ability to regulate itself and provide adequate determinations for disabled Americans.<sup>130</sup>

## 2. DDS Allowance Rate Inconsistencies

Along with these more general concerns, the SSA's non-specialist policy also creates significant allowance-rate inconsistencies among different DDSs so that the likelihood that a person's claim will be approved is often based on where she lives. In 2014, although the average DDS initial allowance rate was 37.06%, there was a significant range when individual states were considered.<sup>131</sup> Specifically, Tennessee DDS agencies only approved 25.55% of the claims filed, while DDS agencies in New Hampshire approved 54.35%.<sup>132</sup> Although particular conditions (such as the economy or the health status of

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128. *Id.* (quoting a doctor who stated that “[d]octors who specialize in nerve disorders ‘would be hard pressed to evaluate diabetes and heart disease and . . . leukemia’”); *see also* Lovinger, *supra* note 124, at 412 (explaining that the evidence Dr. Meltzer has collected regarding physician care suggest “that people who do it more do it better, so there seems to be some advantage”).

129. Along with the financial burden of adjudicating appeals, the long process can have serious repercussions for the claimants, “including worsening illness, drained retirement funds . . . and even foreclosure.” Merline, *supra* note 51, at 25–26.

130. This concern by the public is especially understandable when one considers the long-term impacts that occur when the SSA inaccurately awards disability benefits to an individual. As of October 2014, once an individual is awarded disability benefits, the average amount the government spends during the lifetime of that claimant is \$300,000. Fahrenthold, *supra* note 4. Compounding this problem is the fact that “[v]ery few individuals leave the disability rolls by returning to work or medical improvement; most simply convert automatically to retirement benefits” or, in the case of SSI benefits, continue receiving SSI benefits. PERMANENT SUBCOMM. ON INVESTIGATIONS, *supra* note 4, at 7.

131. SSA *Fiscal Year Disability Claim Data*, SOC. SECURITY ADMIN., <https://www.ssa.gov/disability/data/ssa-sa-fywl.htm> (last visited Dec. 28, 2016) (edited Excel Spreadsheet on file with the author) (although this number includes SSI benefits given to children as well, given the small number of applications under that SSI regulation, this percentage is still applicable).

132. *Id.* This inconsistency has unfortunately persisted for the past few decades. Specifically, in a report prepared by the Institute of Medicine in 2007, the IOM found that: (1) in 2004, the initial allowance rate for individual states ranged from 25.3% to 61.1%; and that (2) a similar range of allowance rates was also observed by the SSA in a 1990 study. INST. OF MED. OF THE NAT'L ACADS., *supra* note 102, at 169.

a state's citizenry) certainly contribute to this almost 30% difference, the SSA found in an internal SSA study that after statistically controlling for these conditions, the conditions only explained half of the variances between the states.<sup>133</sup> Additionally, that same study found that half of the variances were likely caused by differences in state administrative practices, such as how often DDSs use consultative examinations, how involved doctors were in making the disability determinations, and the training practices and qualifications of the decision makers.<sup>134</sup> Consequently, it is not just the individual makeup of certain states that determine how DDSs determine disability claims; it is also the involvement of doctors and the qualifications of their MCs and DEs. By emphasizing or de-emphasizing medical expertise or training of the DDS officials, therefore, DDSs have created a system in which, depending on the state, the claimant has anywhere between a 25% and a 54% chance of receiving SSA disability benefits.<sup>135</sup>

The Institute of Medicine ("IOM") has directly connected this observation (that the medical training of disability decision-makers is an important factor in explaining the differences between DDS allowance rates) to the specialty of the MCs. In a 2005 study requested by the SSA,<sup>136</sup> the IOM found that in 2004, out of the 49 possible SSA specialist categories,<sup>137</sup> 75% of the consultants used by DDSs represented only five specialties: psychology, psychiatry, internal medicine, pediatrics, and family medicine.<sup>138</sup> Importantly, the most commonly claimed physical ailment (musculoskeletal impairments) is not represented by that group.<sup>139</sup> Furthermore, only one of the specialists (psychology) appeared in each DDS while "29 DDSs had no MCs specializing in cardiology, 28 had no neurologists, and 25 had no orthopedic surgeons or

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133. INST. OF MED. OF THE NAT'L ACADS., *supra* note 102, at 169.

134. *Id.*

135. SSA *Fiscal Year Disability Claim Data*, *supra* note 131.

136. Administrative Review Process for Adjudicating Initial Disability Claims, 70 Fed. Reg. 43,590, 43,594 (July 27, 2005) (to be codified at 20 C.F.R. pts. 404, 405, 416, and 422) (explaining that as part of a proposed change to the disability determination process, the SSA was going to work with the Institute of Medicine to determine appropriate goals and standards).

137. *DI 24501.004 Medical Specialty Codes*, SOC. SECURITY ADMIN. (last updated May 5, 2015), <https://secure.ssa.gov/poms.nsf/lnx/0424501004> (listing 49 different specialty codes).

138. INST. OF MED. OF THE NAT'L ACADS., *supra* note 102, at 178. This means that of the five most common specialties, only three (internal medicine, pediatrics, and family medicine) are authorized to make physiological medical determinations and recommendations for DDSs. *See* 20 C.F.R. § 404.1616(f) (explaining that only psychological consultants may examine claimants reporting psychological or psychiatric impairments).

139. In 2013, 35.9% of the SSDI benefits given out were for impairments of the musculoskeletal system. SOC. SEC. ADMIN., PUB. NO. 13-11826, ANNUAL STATISTICAL REPORT ON THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM, 2013, at 95 chart 10 (2014), [https://www.ssa.gov/policy/docs/statcomps/di\\_asr/2013/di\\_asr13.pdf](https://www.ssa.gov/policy/docs/statcomps/di_asr/2013/di_asr13.pdf) [hereinafter 2013 SSDI REPORT]. In 2013, the number of individuals receiving SSI benefits who suffered from musculoskeletal impairments was almost 200,000 more than any other non-psychological disorder. SOC. SEC. ADMIN., PUB. NO. 13-11827, SSI ANNUAL STATISTICAL REPORT, 2013, at 70 tbl.36 (2014), [https://www.ssa.gov/policy/docs/statcomps/ssi\\_asr/2013/ssi\\_asr13.pdf](https://www.ssa.gov/policy/docs/statcomps/ssi_asr/2013/ssi_asr13.pdf) [hereinafter 2013 SSI REPORT].

orthopedic specialists.”<sup>140</sup> This discrepancy could be caused by the simple fact that, other than psychologists, the doctors who are most likely to be employed as MCs for the SSA are retired internal medicine specialists, pediatricians, and family practitioners.<sup>141</sup> This study illustrates two primary points. First, on the bright side, it shows that, at least on a theoretical level, DDS and SSA officials recognize and appreciate the importance of having MCs with appropriate medical specialties, as the study was requested by the SSA to examine the availability of medical experts in all levels of adjudication. Additionally, the authors make particular note of the common inadequacies of DDS MCs throughout the study,<sup>142</sup> illustrating that while there is still no requirement regarding the specialty of MCs, the issue has not gone unnoticed.<sup>143</sup>

However, the second point that this study illustrates is that significant issues arise when particular medical specialties are not available in the area of the country in which the DDS is located. Specifically, because the number of available MCs with sufficient expertise in a given medical field varies widely from DDS to DDS, and the SSA does not have a rule requiring that MCs be specialists in the claimants’ disability, the allowance rates between DDSs are similarly impacted and differentiated unfairly. Much like the example of Mr. Bunn,<sup>144</sup> the failure of the SSA to adequately ensure that MCs are acceptable experts in the field of medicine involving the claimant’s injury creates a sense of arbitrariness and randomness within a system that should be both consistent and understandable. An individual’s ability to receive SSA disability benefits should not depend on where she lives or the availability of certain experts in that state. An Iowan with a neurological injury should not be subjected to review from a pediatrician when a similar claimant in New York may have access to a neurologist. Similarly, the clear discrepancies that the study identified regarding availability of specialized MCs once again indicates to the public that the SSA may not be competently determining who is and is not disabled.<sup>145</sup> Allowing such a policy to continue further harms the fairness and equity of a process that is already cumbersome and time-intensive.

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140. INST. OF MED. OF THE NAT’L ACADS., *supra* note 102, at 178.

141. *Id.* at 179 fig.3; Paletta, *supra* note 119 (explaining that “[m]any medical consultants are retired or semi-retired doctors seeking additional income”).

142. The study details both the lack of availability of specialist MCs throughout the country, and also establishes the significant breadth of the problem when it explains that although 20% of SSA disability claimants suffer from musculoskeletal impairments, only 2.5% of the MCs in the country are orthopedists. INST. OF MED. OF THE NAT’L ACADS., *supra* note 102, at 178–79.

143. *See infra* notes 145–56 and accompanying text (illustrating that this recognition was later formalized into an official proposal which went into effect for approximately two years in Region 1 of the United States).

144. Paletta, *supra* note 119.

145. Although scholars and economists have primarily focused on the issue of inconsistency and arbitrariness when it comes to the high allowance rate among ALJs, see Pierce, Jr., *supra* note 4, at 36 (noting that the variation of ALJ allowance rates in 2011, which ranged from the average of 60% to 95% for 27 ALJs, “is inherently inconsistent with an accurate decisionmaking process”), the same theories apply to the discrepancies observed among DDSs. Specifically, in 1997, the United States

A final example of the issues inherent in the SSA's non-specialist consultant policy is the fact that the SSA itself both recognized the problem and attempted to fix it. In an effort to "ensure that the right set of medical eyes reviews medical records and answers questions about the wide variety of impairments seen in disability claims,"<sup>146</sup> in March 2006, the SSA established the Medical and Vocational Expert System ("MVES") for Region 1, or New England.<sup>147</sup> The MVES was comprised of a Medical and Vocational Expert Unit and a national network of medical, psychological, and vocational experts who were expected to meet specific standards established by the SSA.<sup>148</sup> Because the MVES was going to be organized and maintained by the SSA, instead of the state agencies, the MVES was primarily envisioned as a tool for ALJs and federal reviewing officials to make disability determinations at the appellate level.<sup>149</sup> However, if the DDS did not have a consultant with a specific medical specialty that was necessary to make a disability determination because of the complexity of the case, "the MVES [would], to the extent practicable, provide such assistance" to the DDS.<sup>150</sup> Importantly, this additional DDS assistance was only envisioned for instances in which the claims "involve[d] difficult or complex issues requir[ing] medical specialist or subspecialist expertise,"<sup>151</sup> such as diseases of the skin.<sup>152</sup> Consequently, although the MVES proposal illustrates that the SSA understands the importance of medical specialists in rare cases and for ALJs, it did not sufficiently respond to the more general issues that occur when a cardiologist evaluates an orthopedic claim, as such a claim would likely fall under the "general disability impairments" that would continue to be entrusted to non-specialists MCs.<sup>153</sup>

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General Accounting Office ("GAO") explained that the significant differences between ALJ and DDS allowance rates created questions "about the fairness, integrity, and cost of SSA disability programs." U.S. GEN. ACCOUNTING OFFICE, *SSA MUST HOLD ITSELF ACCOUNTABLE FOR CONTINUED IMPROVEMENT IN DECISION-MAKING* 3 (1997), <http://www.gao.gov/assets/160/155981.pdf>.

146. Administrative Review Process for Adjudicating Initial Disability Claims, 70 Fed. Reg. 43,590, 43,594 (July 27, 2005) (to be codified at 20 C.F.R. pts. 404, 405, 416, and 422).

147. Administrative Review Process for Adjudicating Initial Disability Claims, 71 Fed. Reg. 16,424, 16,431 (Mar. 31, 2006) (to be codified at 20 C.F.R. pts. 404, 405, 416, and 422).

148. *Id.*

149. *Id.* (noting that while "[f]ederal reviewing officials and administrative law judges who request the assistance of a medical, psychological, or vocational expert must do so through the MVEU," DDSs would only use the MVES if the DDS did not already have a medical consultant in a specific medical specialty).

150. *Id.*

151. *Id.* (noting that "[w]hile many disability impairments may be properly evaluated by medical generalists, claims that involve difficult or complex issues require medical specialist or subspecialist expertise").

152. In 2013, only 0.2% of all SSDI and SSI claims were diseases of the skin. 2013 SSDI REPORT, *supra* note 139, at 26 tbl.6; 2013 SSI REPORT, *supra* note 139, at 73 tbl.38.

153. Administrative Review Process for Adjudicating Initial Disability Claims, 71 Fed. Reg. at 16,432.



Two years after the SSA established the MVES in New England, the SSA subsequently disbanded the program.<sup>154</sup> In its decision, the SSA cited both administrative costs of the national program and the SSA's need to focus on the backlog of disability claims.<sup>155</sup> The SSA also explained that staffing the MVES office was more expensive than it had anticipated.<sup>156</sup>

### C. AGGRAVATION OF THE INHERENT ISSUES

This Subpart will briefly explain two current concerns that are both exacerbating the inherent issues involved in having non-specialist MCs at the DDS level, while also confirming the need to have such specialists. As mentioned above, due to the Great Recession in 2008,<sup>157</sup> the number of disability claims filed with DDSs and, therefore, the number of claims pending, have consistently increased.<sup>158</sup> Consequently, the amount of work and the pressure to diminish this backlog of pending claims has created a push at both the ALJ and DDS levels to decide as many claims as possible.<sup>159</sup> Most scholars and economists have focused on the impact that this backlog-push has had on the astronomical ALJ disability allowance rates.<sup>160</sup> However,

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154. Suspension of New Claims to the Federal Reviewing Official Review Level, 73 Fed Reg. 2,411, 2,412 (Jan. 15, 2008) (to be codified at 20 C.F.R. pts. 404, 405, and 416); *SSA Moves to Restore Traditional Disability Determination Procedures to Region I Letter No. 776*, UNEMPL. INS. REP. (CCH) 2009 WL 10631245, at \*1-2 (Dec. 14, 2009) (noting that "by March 23, 2008, the SSA had suspended new claims processing through the . . . Office of Medical and Vocational Expertise").

155. Suspension of New Claims to the Federal Reviewing Official Review Level, 73 Fed Reg. at 2,412 (explaining that "[o]ur experience . . . demonstrates that the administrative costs associated with the OFedRO and its use of the MVES/OMVE to develop medical and vocational evidence is greater over the foreseeable future than originally anticipated"); *SSA Suspends Federal Reviewing Official Evaluations Letter No. 682*, UNEMPL. INS. REP. (CCH) 2008 WL 11194900, at \*1-3 (Jan. 28, 2008) (noting that in recognition of a GAO "report that the backlog of disability claims has doubled in the past decade . . . the SSA announced that it is suspending step two of the redesigned review process . . . which also includes the new Medical and Vocational Expert System").

156. Suspension of New Claims to the Federal Reviewing Official Review Level, 73 Fed Reg. at 2,412 ("The agency does not have the resources to both fully staff the new OFedRO and MVES/OMVE and also resolve the growing disability hearing backlog.").

157. See *supra* text accompanying notes 51-53 (explaining the role of the Great Recession in the increase in SSA disability applications).

158. OFFICE OF THE INSPECTOR GEN., *supra* note 56, at 5 (showing that between 2008 and 2010, the number of initial pending claims rose from 565,284 to 842,192). Although the number of pending claims decreased to 698,127 in 2013, the backlog is not expected to return to pre-2008 levels. *Id.*

159. *Id.* at 1 (detailing the steps the SSA took to reduce the initial claims backlog in 2010, including "[e]xpand[ing] the use of screening tools to assist in identifying claims likely to be allowed" and "[r]efin[ing] policies and business processes to expedite case processing").

160. Katsiotas, *supra* note 54, at 693-94 (explaining how the SSA responded by instituting a "paying-down-the-backlog 'policy'" and encouraging ALJs to approve as many claims as possible); see also PERMANENT SUBCOMM. ON INVESTIGATIONS, *supra* note 4, at 20 (explaining that in an effort to reduce the backlog, "ALJs were encouraged to decide no fewer than 500 cases per year" and that "making a proper decision and producing a high quality written description of that decision on more than one case per day is difficult").

the push to decide disability claims quickly has also had a significant impact on the use of specialty MCs at the initial determination level. While one of the actions taken by the SSA to diminish the backlog was to hire more DEs and MCs,<sup>161</sup> by late 2011, the SSA also began allowing MCs to stray further from their area of medical expertise when making disability determinations.<sup>162</sup> Specifically, doctors reported being “pressured to change their medical opinions to conform to targets or goals set by SSA officials” and were increasingly required to work on claims in medical areas they were unfamiliar with.<sup>163</sup> Not only did several doctors express concern that the accuracy of their decisions were limited or diminished because they were making decisions outside their specialties, but in response to the increased move toward non-specialist MCs, for example, many of the MCs in the Baltimore SSA office left, thereby having the exact opposite impact desired by the SSA.<sup>164</sup>

While this change was implemented in order to ensure a faster, arguably better disability determination process, it explicitly exacerbated the two inherent concerns detailed above: mistrust and inaccuracy. First, the pressure encourages MCs to ignore the importance of their expertise in their determinations, thereby causing the public and the claimants to further distrust whether the SSA can accurately determine who is and is not disabled.<sup>165</sup> Second, this push also increases the likelihood that doctors will inaccurately consider the medical evidence in the claimant’s file and may “award benefits to those who don’t qualify and deny benefits to those who are entitled,”<sup>166</sup> thereby further contributing to the already-established discrepancies amongst DDSs across the country.

Another contemporary change aggravating some of the issues inherent in non-specialist MCs is a 2012 amendment that eliminated the previous requirement for a DDS official or an ALJ to re-contact the claimant’s treating

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161. OFFICE OF THE INSPECTOR GEN., *supra* note 56, at 1.

162. Paletta, *supra* note 119.

163. *Id.* (“After the procedures were implemented in Baltimore, an eye doctor was assigned back-pain cases . . . . A dermatologist reviewed the files of someone who had a stroke. A gastroenterologist reviewed the case of someone with partial deafness . . . .”). Importantly, if these allegations are true, some of them would indicate that the SSA was encouraging MCs to ignore the SSA’s other regulations, as an optometrist is permitted to make determinations on “visual acuity and visual fields only.” 20 C.F.R. § 404.1513(a)(3) (2016).

164. Paletta, *supra* note 119 (noting that, according to the SSA, 45 out of the 140 MCs left the office after the changes were announced and implemented).

165. Coupled with the well-published reports on the astronomical ALJ allowance rates, see, e.g., U.S. GEN. ACCOUNTING OFFICE, *supra* note 145, at 3 (explaining that discrepancies between ALJ and DDS decisions create questions “about the fairness, integrity, and cost of SSA disability programs”); and Pierce, Jr., *supra* note 4, at 34–39 (detailing how ALJs consistently grant far too many SSA disability claims on appeal and cost the SSA upwards of \$2 billion per year in unnecessary salaries), such skepticism and frustration is understandable, and also a huge concern for the SSA as it attempts to implement new programs designed to attack both the backlog and its funding issues. See *supra* Part III.C (discussing backlog concerns) and note 3 (discussing funding concerns).

166. Paletta, *supra* note 119.

physician if there was an inconsistency in the claimant's medical evidence.<sup>167</sup> According to the SSA, in an effort to further streamline the adjudicative process, “[d]epending on the nature of the inconsistency or insufficiency, there may be other, more appropriate sources from whom we could obtain the information we need.”<sup>168</sup> Consequently, instead of simply requesting that the claimant's treating physician explain or clarify any inconsistencies in the claimant's medical evidence, DDS officials and ALJ have even more latitude than before to consider the medical evidence on their own to determine how best to create the medical record, whether to order CEs, and what to do with inconsistent information.

Because the amendment arguably destroys the “fundamental safeguard” of the re-contact rule that was in place to stop non-medical SSA officials from making medical determinations,<sup>169</sup> the amendment implicates the same MC issues described above. Specifically, the amendment adds to the mistrust among claimants, who yet again see the deference afforded to their treating physicians' opinions severely diminished. Additionally, the amendment increases the likelihood of inaccurate rulings: because non-medical DEs and ALJs are given more authority to decide how to accurately weigh inconsistent medical evidence, they have a greater incentive to make more and more medically detailed decisions, although neither are trained physicians.<sup>170</sup> This is particularly true since there has been a significant shift toward clearing the backlog of pending applications. As DEs and ALJs are encouraged to make as many determinations as possible, this amendment therefore further encourages them to forgo the extra step of re-contacting in order to rectify inconsistencies or missing evidence themselves.

In both its tone and effect, this amendment reaffirms a current need to have MCs who are trained medical specialists. An MC's subsequent review of the file (and any additional information requests or CE requests that the MC may order) can provide an additional safeguard between the non-medical DE and the medical disability determination, thereby mitigating any damage

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167. How We Collect and Consider Evidence of Disability, 77 Fed. Reg. 10,651 (Feb. 23, 2012) (to be codified at 20 C.F.R. pts. 404 and 416).

168. *Id.*

169. Amrita Maharaj, Note, *The Lack of Deference to Medical Opinions in Adjudicating Social Security Disability Claims*, 63 BUFF. L. REV. 207, 210 (2015) (“The amendment destroys the fundamental safeguard against an ALJ playing doctor. No longer do ALJs have any obligation to defer first and foremost to professional medical opinions in evaluating disability claims. An ALJ can interpret medical evidence as he so chooses and can decide how to resolve insufficiencies or inconsistencies in any number of ways . . .” (footnote omitted)). Although Maharaj's piece focuses on the impact of the amendment on ALJ decisionmaking process, because DDS officials are governed by the same rules as ALJs, this amendment also applies to DDS officials such as DEs and MCs. 20 C.F.R. § 404.1615(a) (2016).

170. See INST. OF MED. OF THE NAT'L ACADS., *supra* note 102, at 176 (describing a DE as a “layperson”); Maharaj, *supra* note 169, at 207–08 (explaining that ALJs are not professionally trained medical experts).

caused by this amendment. Furthermore, having specialist MCs perform this mitigation (as opposed to non-specialist MCs) will be particularly effective as specialists are better able and quicker at identifying inconsistencies, determining what information is actually necessary to reconcile that inconsistency, and requesting that information with necessary precision so that additional work is not created. Additionally, a specialist MC's expertise in the complexities of the claimant's specific disability will provide the MC with a better understanding of how inconsistent medical evidence may impact the particular type and severity of the ailment.<sup>171</sup> Therefore, although current trends largely reinforce and exacerbate some of the inherent non-specialist issues detailed in Part III.A, this Note contends that specialist MCs also provide a possible solution to some of the concerns raised. Part IV will consider some of these possible solutions in more detail.

#### IV. SUGGESTIONS FOR IMPROVEMENT

This Part provides two different suggestions aimed at improving upon some of the concerns raised in this Note, specifically the inconsistencies among DDSs, the lack of available specialists among the MCs, the move toward quickly diminishing the backlog, and the lack of trust and confidence in the SSA determination system, especially given the 2012 amendment. The first proposal suggests making regionals specialists and sub-specialist MCs available to DDSs, while the second proposal suggests a change in the SSA regulations and how the SSA collects and analyzes its disability data.

##### A. SUB-SPECIALISTS AND REGIONAL SPECIALISTS

###### 1. Sub-Specialists Overview

In recognition of the cost of the MVES and the current dire economic conditions for both the SSI and SSDI funds,<sup>172</sup> instead of creating an entirely new department, this Note first proposes better utilizing the MCs that the DDSs currently employ. Specifically, while the SSA and DDSs should continue to work together to attract the widest variety of specialist MCs possible, the most common and prolific general MCs (generalists, pediatricians, and family practitioners)<sup>173</sup> should be divided into sub-specialist groups based on the 12 Listing of Impairments that they are allowed to evaluate under the regulations.<sup>174</sup> Consequently, instead of having a variety of pediatrician or

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171. Lovinger, *supra* note 124, at 411–12 (quoting Dr. David Meltzer as he explains that “[a]ll the differences we’re finding over time seem to be explained by increases in disease-specific experience—the more you do it, the better you do it. The more pneumonia you see, the better you get at [caring for patients with] pneumonia. You don’t necessarily get better at asthma if you take care of pneumonia, but you get better at pneumonia.” (alteration in original)).

172. *See supra* note 3.

173. *See* INST. OF MED. OF THE NAT’L ACADS., *supra* note 102, at 178 (explaining that the most common non-psychological MCs are internists, pediatricians, and family practitioners).

174. These include the musculoskeletal system, the cardiovascular system, hematological

family practitioner MCs reviewing a variety of different claims, a DDS may have a sub-specialist MC in cancer or neurological disorders. The division of the sub-specialties and the number of MCs in each sub-specialty will vary from DDS to DDS in order to adequately represent the types and frequencies of the specific impairments each DDS evaluates annually. For example, if a DDS in Pennsylvania investigates endocrine disorders the most frequently, then the endocrinologist MC sub-specialists should outnumber the skin disorder MC sub-specialists in that DDS. Dividing the sub-specialties this way will ensure that there are a sufficient number of sub-specialist MCs per DDS. Additionally, this division will guarantee that the responsibilities and number of claims evaluated will be equally divided amongst the sub-specialist MCs, as the number and type of sub-specialist MCs in a DDS should be determined by the frequency of specific impairments in that particular DDS.

## 2. Sub-Specialists Training

Once the general MCs are divided into their sub-specialties (based on either the MC's personal preference or the MC's competence level in a certain specialty), each sub-specialist MC will only be responsible for evaluating disability claims in their sub-specialty. Consequently, a respiratory system MC will only evaluate respiratory-based disability claims. Additionally, after the MCs have been divided, they will undergo one extensive, centralized training session<sup>175</sup> within their region<sup>176</sup> which will be organized by the SSA. This session will teach them to become more familiar with their particular

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disorders, congenital disorders, cancer, the digestive system, skin disorders, neurological disorders, immune system disorders, impairments of the respiratory system, genitourinary disorders, and endocrine disorders. *Disability Evaluation Under Social Security: Listing of Impairments—Adult Listings (Part A)*, *supra* note 79.

175. While the SSA would ultimately be responsible for determining the appropriate qualifications for each sub-specialty, as a general framework, the SSA should strongly consider the national qualifications that exist for each specialty as a baseline of qualifications. See INST. OF MED. OF THE NAT'L ACADS., *supra* note 102, at 198–99 (explaining that, per Recommendation 1-7, all medical experts used by ALJs should be board certified). This training will also focus on the regulations of the SSA and, more importantly, how each specialty may interact with those regulations. Therefore, a musculoskeletal system sub-specialist MC will learn how musculoskeletal impairments may manifest themselves as disabilities and will focus particularly on what factors are usually present in order to make that impairment severe enough to qualify as a disability under the SSA's regulations. The specialist will also learn what types of records and data a musculoskeletal specialist may look at first when making such a determination, so the sub-specialist knows which records are the most important to be able to make a quick and accurate determination.

176. Although, ideally, each state would perform its own centralized training for all the DDS offices within its borders (especially if there is only one DDS), if there are insufficient full-specialists to provide and monitor the training through the SSA, certain states may be grouped together in regions similar to the breakdown of SSA regions today. *Organizational Structure of the Social Security Administration*, SOC. SECURITY ADMIN., <https://www.ssa.gov/org/dco.htm#sb=2> (last visited Dec. 29, 2016) (showing ten different SSA regions throughout the country). Also, this division may be a good idea in order to save time and resources instead of conducting more than 50 trainings in each state for each sub-specialty.

sub-specialty, thereby ensuring that each sub-specialist MC understands the medical impairments associated with the specialty in a much more detailed and comprehensive way.

Following this singular training session, this Note proposes follow-up trainings within individual DDSs. While this idea for specialized training is similar to the training that was offered to non-specialist MCs in Baltimore, this Note recommends something more extensive than an hour-long seminar.<sup>177</sup> Instead, it is based on the model used by many DDSs,<sup>178</sup> whereby an established MC who is licensed in the sub-specialty provides on-the-job training to new MCs and gradually allows the new MCs to work on more difficult cases. This subsequent one-on-one or group mentoring training module will ensure that the sub-specialists are adequately trained in the sub-specialty by full-specialists, who will be better able to point out patterns or particularly useful medical evidence as it relates to the sub-specialty and SSA regulations.<sup>179</sup>

### 3. Sub-Specialists and Regional Specialists

Admittedly, the previous two Subparts assume that: (1) each DDS will have at least one full-specialist that specializes in each listed impairment to provide one-on-one or group mentoring in that sub-specialty; and (2) that each DDS office hears an adequate number of claims based on each listed impairment to justify having, for example, at least one skin disease sub-specialist MC. This Note proposes two possible solutions to respond to such concerns. First, if there are not enough annual specialized claims in a DDS to warrant the creation of a sub-specialist MC, and a DDS receives a claim in the neglected area that meets the basic requirements for SSI or SSDI benefits, then that DDS will transfer the claim to a nearby DDS that has either a full-specialist MC, or a sub-specialist MC. This transfer will be easily achieved given the SSA's use of the eDib computerized system, which digitizes the claimant's medical file.<sup>180</sup>

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177. Paletta, *supra* note 119 (explaining that, in response to some complaints that MCs were unfamiliar with certain impairments, the SSA provided hour-long seminars to prepare non-specialist MCs to review cases involving specialized impairments such as hematological disorders).

178. INST. OF MED. OF THE NAT'L ACADS., *supra* note 102, at 187 (explaining that, when an MC begins training, MCs usually train under established MCs until the new MCs are able to independently evaluate more difficult disability claims).

179. This specialized training will also consistently and repeatedly reaffirm the intensive training initially provided by the SSA and will ensure that the sub-specialist MCs are able to more quickly identify patterns among disability claims in the sub-specialty so as to more quickly and competently evaluate claims.

180. Privacy Act of 1974, as Amended; New Systems of Records and New Routine Use Disclosures, 68 Fed. Reg. 71,210, 71,214 (Dec. 22, 2003) (explaining that "[o]ther authorized Federal and State agencies that have access to the current paper disability folder will also have electronic access as needed to the eDib claim file" and that the file "may contain the application for benefits [and] supporting evidence and documentation for initial and continuing entitlement"); *see also* INST. OF MED. OF THE NAT'L ACADS., *supra* note 102, at 168 ("SSA's eDib system includes a mixture of structured data and

Second, in order to provide for continued mentoring for each sub-specialist MC, regardless of the availability of a full-specialist in a particular DDS, each region will have at least one regional full-specialist for each impairment. Following the centralized, extensive training, that regional specialist can, at the beginning of this program, provide general mentoring to sub-specialists in DDSs without full-specialist MCs in their given specialty. Again, because of the digitized records and ever-improving technology through which MCs may communicate with each other, such coordination will be possible and will ensure regional uniformity.

#### 4. Sub-Specialists: Advantages

Although this solution does not permanently respond to some of the broader and more lasting concerns facing the SSA, it does provide a workable stopgap measure that recognizes the financial costs inherent in any major administrative change. It also focuses on the necessity to both diminish the inconsistencies among DDSs and to also quickly and accurately adjudicate disability claims.

This proposed division and training can have multiple, positive effects on the disability determination process. First, this basis in knowledge (established both through the training and the repeated exposure to certain injuries) will allow MCs to eventually move more quickly through claims, since MCs will know what kind of evidence is required to prove a disabling back injury as opposed to a disabling shoulder injury.<sup>181</sup> Furthermore, if evidence is missing from the file, the MC will be quicker to notice (since the MC knows more specifically what she is looking for) and, subsequently, more precise in her request for the evidence.<sup>182</sup> Additionally, because the sub-specialist MC will be

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images, with the medical evidence portion of the file consisting of images of paper medical records. This will make it possible for medical experts in remote locations to review medical records . . .”). Treating physicians will also be able to send information to MCs who may be stationed further away through the Electronic Records Express initiative, whereby doctors can electronically send DDSs health records or versions of forms that the SSA requests them to fill out. SOC. SEC. ADMIN., PUB. NO. 05-10046, USE ELECTRONIC RECORDS EXPRESS TO SEND HEALTH RECORDS 2–3 (2010), <https://www.ssa.gov/pubs/EN-05-10046.pdf>.

181. Lovinger, *supra* note 124, at 411–12. This understanding that extended exposure to certain areas of study will produce more thoughtful, precise decisions has been supported both by historical physicians and by more modern journalists. See George Weisz, *The Emergence of Medical Specialization in the Nineteenth Century*, 77 BULL. HIST. MED. 536, 547 (2003) (paraphrasing the 19th-century physician Jean-Emmanuel Gilibert: “[M]edical science . . . depended on careful, methodical observations informed by a vast knowledge of the subject that permitted the physician to reflect, judge, make connections, and generalize. One who specialized in certain maladies could master the entire literature in his field, and generalize the views of his predecessors in order to develop canons of practice.” (footnote omitted)); Casey B. Mulligan, *Reaping the Grains from Specialization*, N.Y. TIMES: ECONOMIX (Mar. 18, 2009, 6:39 AM), <http://economix.blogs.nytimes.com/2009/03/18/reaping-the-gains-from-specialization/> (“Research has shown, and pay scales confirm, that highly specialized medical doctors are more productive—make better diagnoses and fewer mistakes—than do general internists and general practitioners.”).

182. It is also possible that having a sub-specialist involved in the disability determination

trained on one specific type of injury, she will be able to better relate various types of evidence (conflicting or supporting) to that disability in more complex and comprehensive ways.<sup>183</sup> Consequently, the MC will be more successful and quicker at resolving any medical or informational discrepancies as they relate to the claimant's disability, thereby possibly reinstating a knowledgeable "safeguard" between the DE and the conflicting medical evidence that the 2012 amendment largely abolished.<sup>184</sup> Finally, by providing sub-specialist MCs with these necessary tools to move more quickly through detailed, and sometimes inconsistent medical files, this proposal hopes to maintain the DDSs' impressive reduction in the initial disability claims backlog<sup>185</sup> without sacrificing the specialty and important input of the MCs.<sup>186</sup>

Second, along with improving upon both the production of initial clearances and also the successful resolution of inconsistencies in a claimant's record, this proposal can also lead to more accurate decisions and ultimately save the SSA program administrative costs. First, because this proposal requires very little direct recruiting or hiring by the DDSs or the SSA, and instead utilizes the consultants who are already employed by both, any transportation or training costs will be up-front and significantly less than the MVES program, which required the establishment of an entire office and the acquisition of additional specialists for a national, coordinated program.<sup>187</sup>

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process may increase the likelihood that a claimant's treating physician or consultative examiner (often the same person) will provide more detailed responses to the DDSs' requests. Specifically, because some treating physicians are reticent to provide information that may harm their patient's chance of receiving benefits, the Institute of Medicine found "that many treating sources who do respond to [DDS] requests . . . only provide copies of records, not their judgment of the patient's functional capacities." INST. OF MED. OF THE NAT'L ACADS., *supra* note 102, at 195. However, if: (1) the request came from a person who was specifically trained to respond to the claimant's injury, as opposed to a non-specialist MC (whose competency the treating physician may be suspicious of); and (2) the request was extremely precise in its focus, a treating physician may feel more comfortable providing more thorough responses. This would thereby assist the DDSs in establishing an adequate medical record with which to make an accurate disability determination. *See id.* at 176 (noting that along with providing medical opinions on disability claims, MCs also "develop[] and maintain[] relationships with the medical community").

183. *See generally* Weisz, *supra* note 181.

184. *See* Maharaj, *supra* note 169, at 208 (explaining the importance of the "safeguard" between a DE and detailed, contradictory medical decisions); Mulligan, *supra* note 181 (explaining that data has shown that specialists are both more productive and more accurate).

185. OFFICE OF THE INSPECTOR GEN., *supra* note 56, at 1-4 (detailing the consistent reduction in the backlogged claims beginning in 2010). Additionally, by providing tools for MCs to move more quickly through DDS claims, this proposal directly supports two of the four enumerated goals of the SSA regarding the backlog: "expand[ing] the use of screening tools" and "refin[ing] policies and business processes to expedite case processing." *Id.* at 1.

186. *See generally* Paletta, *supra* note 119.

187. Suspension of New Claims to the Federal Reviewing Official Review Level, 73 Fed. Reg. 2,411, 2,412 (Jan. 15, 2008) (to be codified at 20 C.F.R. pts. 404, 405, and 416) ("The agency does not have the resources to both fully staff the new OFedRO and MVES/OMVE and also resolve the growing disability hearing backlog."). Because this proposal: (1) focuses on the use



Additionally, as explained above, because the sub-specialists will have a better understanding of what evidence needs to be developed or presented for a specific impairment to become totally disabling, having sub-specialist MCs review the file will lead to more fully developed case files and better evaluated claims.<sup>188</sup> Finally, just as non-specialist MCs inspire individuals like Mr. Burr to appeal a decision,<sup>189</sup> “[i]f cases could be better evaluated and the medical record more fully developed at the beginning of the process, there might be fewer appeals and fewer allowances on appeal.”<sup>190</sup> Considering that an individual determined to be disabled (1) rarely returns to work,<sup>191</sup> and (2) usually costs the SSA \$300,000 in benefits during the person’s life,<sup>192</sup> more accurate initial decisions and fewer appeals can have a huge cost-saving impact.

Third, because sub-specialist MCs are more likely to develop detailed case records, or at least provide more comprehensive explanations or medical opinions regarding the claimant’s impairment, if the claimant does appeal the decision to an ALJ, the ALJ will be in a better position to both incorporate any new evidence the claimant has presented at the hearing, and also to deny the claimant’s appeal if appropriate. One of the reasons for the astronomical allowance rates among some ALJs in previous years was largely the push by the SSA to decide more cases and the recognition among ALJs “that saying ‘yes’ is a lot easier—and faster—than saying ‘no.’ A negative decision often requires a lengthier write-up [and] means 10 pages of text to prepare for a future appeal.”<sup>193</sup> Consequently, by providing better-reasoned and better medically supported DDS determinations, sub-specialist MCs may be able to provide ALJs with a clearer basis to deny a claimant’s claim more frequently, so that saying “no” is just as easy as saying “yes.” As the Institute of Medicine explained in its support of the MVES, although “[m]aking the correct decision initially will require more resources at the front end of the disability decision-making process . . . these costs could be offset by savings from lower appeals rates.”<sup>194</sup>

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of sub-specialist MCs at the initial disability determination level rather than ensuring that they actively participate in multiple determination levels; and (2) primarily uses the MCs already employed in specific regions, the coordination and staffing concerns that played such a key role in the disbandment of the MVES are tremendously reduced.

188. See Administrative Review Process for Adjudicating Initial Disability Claims, 70 Fed. Reg. 43,590, 43,594 (July 27, 2005) (to be codified at 20 C.F.R. pts. 404, 405, 416, and 422) (“In crafting the new approach, [the SSA] realized . . . that having sufficient expertise to help us consider the medical and vocational issues in claims filed throughout the country would be essential to an efficient, accurate, and fair adjudication process.”).

189. See *supra* Part III.B.

190. INST. OF MED. OF THE NAT’L ACADS., *supra* note 102, at 173.

191. PERMANENT SUBCOMM. ON INVESTIGATIONS, *supra* note 4, at 7.

192. Fahrenthold, *supra* note 4.

193. *Id.*

194. INST. OF MED. OF THE NAT’L ACADS., *supra* note 102, at 172–73.

A final advantage to creating sub-specialist MCs throughout the country is that they would provide much more consistent decisions and improve upon the public's trust in the SSA's disability process. As noted above, one of the primary concerns with having non-specialist MCs is that the approval rates and decisions in each state vary widely depending on the availability of specialists.<sup>195</sup> However, by suggesting full-specialist and sub-specialist MCs, this proposal provides a comprehensive way to naturally create more consistent decisions, both initially and at the ALJ stage of the process. Specifically, because specialists are more likely to come to similar decisions about a certain case than non-specialists considering the same case, by ensuring that each claim will be heard by, at the very least, a sub-specialist MC, the possibility that a respiratory claimant in Nevada will have a similar quality MC review as a respiratory claimant in Massachusetts is much higher than it is under the current system. Consequently, an individual's chance of approval will not depend on where she lives, but rather the substance of her claim. This improvement will not only create a much-needed uniformity among different DDSs, but will also go a long way to improving the public's perception of the SSA as a fair and equitable agency that accurately determines whether someone is or is not disabled.

#### B. ALJ EXPLANATION REQUIREMENT AND DATA ANALYSIS

Along with suggesting a re-organization and re-focusing of the current SSA MC system, this Note also offers an alternative, less dramatic proposal focusing on the content of the written disability decisions. Under the current regulations, an ALJ and DDS must evaluate every medical opinion it receives regarding the claimant's ailment, including the determination of medical consultants.<sup>196</sup> In cases where the official does not give controlling weight to the treating physician's medical opinion, the official must consider six factors: the examining relationship, the treatment relationship, supportability, consistency, specialization, and other factors.<sup>197</sup> While the official must, theoretically, consider all of these factors, in the actual written decision, the official only has to explain "the weight given to the opinions of a State agency medical or psychological consultant."<sup>198</sup> Consequently, an ALJ or DDS official may issue an opinion based on a neurological claim in which it weighs the opinion of a pediatrician MC over that of a treating neurological physician's medical opinion, without addressing the issue of the MC's specialty.<sup>199</sup>

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195. See *supra* notes 138–43 and accompanying text (connecting the inconsistencies between approval ratings among DDSs and the availability of specialist MCs and psychological consultants).

196. 20 C.F.R. § 404.1527(c) (2016).

197. *Id.* § 404.1527(c)(1)–(c)(6).

198. *Id.* § 404.1527(e)(2)(ii).

199. Interestingly, in the PSI Minority Report in 2012, the Senate noted that even in cases where there was conflicting evidence between the opinions of two doctors so that the ALJ was

Without addressing this concern, the opinions produced under this regulation provide little guidance to either claimants attempting to navigate the disability process, or adjudicators deciding how to weigh the specialty of the opinion evidence it receives, whether on the treating physician or MC side.

Therefore, this Note proposes: (1) collecting and analyzing the specialties of the MCs currently employed; and (2) requiring ALJs and DDS officials to explain in their issued opinions how the medical professionals' specialties impacted how they weighed the opinion evidence in an individual case. Under the current system, whenever an MC signs a document, they are required to include a medical specialty code that corresponds to their area of expertise.<sup>200</sup> Therefore, there is a tremendous amount of data available, which can and should be analyzed to recognize and isolate patterns concerning specific specialties. For instance, the data may indicate that, based on the types of specialties that are cited in appeals, reversals, or denials, there is a clear disconnect between a particular specialty or group of specialties and a claimed disability, so that the disability is consistently causing confusion and additional time and money to adjudicate correctly. Knowing this information may indicate to the SSA that it should require that that disability be examined by a specific specialist (much like it does for psychology or speech-impairments).<sup>201</sup> This data may also indicate that MCs in a particular region may need to be re-trained on a type of claim or ailment. Finally, this analysis will allow the SSA to further examine the state of its MC system to determine how and where more specialists can be hired and trained.

Similar advantages arise from this Note's second suggestion, namely requiring ALJs and DDSs to explicitly explain how they are weighing and considering a specialist's expertise. Because ALJs and DDSs are already (presumably) engaging in this type of examination and analysis when making their decisions, formalizing these thoughts into their opinions will reveal patterns regarding both the importance of the specialty in the medical opinion, and its connection to the evaluation of the claimant's claim. Furthermore, because this analysis will come directly from ALJs and DDSs, claimants will have a better understanding of what, exactly, is expected of them when presenting information or evidence to SSA officials. Finally, ALJs and DDS officials will have better guidance with which to accurately and consistently weigh the specialty factor of section 404.1527(c). These suggestions will not only provide clearer, understandable guidelines for ALJs and DDS officials, but will also allow the SSA to further investigate its own

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required to explain the weight it gave to one opinion over the other, ALJs often failed to meet even that threshold. PERMANENT SUBCOMM. ON INVESTIGATIONS, *supra* note 4, at 118–19.

200. *DI 24501.004 Medical Specialty Codes*, *supra* note 137.

201. See 20 C.F.R. § 404.1513(a)(3)–(a)(5) (explaining that only licensed optometrists, podiatrists, and qualified speech-language pathologists may investigate a claim if the claim is, respectively, a visual disorder, an impairment of the foot, or a speech or language impairment).

system to determine whether there are simple, cost-effective ways to improve its accuracy and accessibility.

#### V. CONCLUSION

Although the SSDI and SSI benefit programs continue to hurtle toward an economically imperiled future, the SSA must remain cognizant of its options for its disability determination process. This multi-step progression can either be a political, public and economic weight on the SSA, or a way for the SSA to re-establish its commitment to fully serve both the disabled worker and the taxpayer. In its current form, the SSA unfortunately reinforces the former description. It both fails to acknowledge the importance of having qualified and specialized medical consultants at the initial determination level and enacts new regulations and guidelines that actively exacerbate inaccuracy and the appearance of arbitrariness among the public. In an effort to solve one issue, the SSA is unfortunately ignoring one of its greatest weapons: qualified and knowledgeable physicians who are the best equipped to deal with both the simple and also complicated cases that the SSA hears daily. By examining and critiquing one of the more basic and constant components of the disability determination process (MC participation and specialization), this Note hopes to reinforce both the importance and the possibility of providing adequate, fair, and quick determinations through more uniquely specialized MCs and better-reasoned decisions. Not only will such a proposal improve the public's belief that the SSA is capable of fairly adjudicating cases, but internally, it can also have positive, wide-reaching and cost-saving effects on the future of the SSA's disability determination process.